Royal Berkshire NHS Foundation Trust

Safeguarding, Mental Health & Learning Disability Annual Report 2020/21

The Safeguarding Mental Health & Learning Disability Team

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CONTENTS

Executive summary

Welcome to the Royal Berkshire NHS Foundation Trust Annual Report for 2020/21. I am pleased and proud to present another report that demonstrates our commitment to safeguarding vulnerable people. As anticipated during the Covid19 pandemic we have faced unprecedented challenges to support and safeguard the vulnerable. We have seen reductions in activity followed by surges and a significant increase in complexity and intensity of cases from a clinical, safeguarding and a psycho-social context in relation to specific patient groups:

- pregnant women, unborn babies and babies under six months
- children and young people from troubled families
- children, young people and adults with complex mental health presentations particularly eating disorders, disordered eating and neurodiversity
- children, young people and adults with a learning and complex neurodisability
- adolescents (13 – 24) presenting and admitted with risk taking behaviours, including injury due to violence
- drug and alcohol presentations and cases involving domestic abuse
- older people presenting due to Covid19 infection and those who lack mental capacity
- older people with their mental health who were more unwell

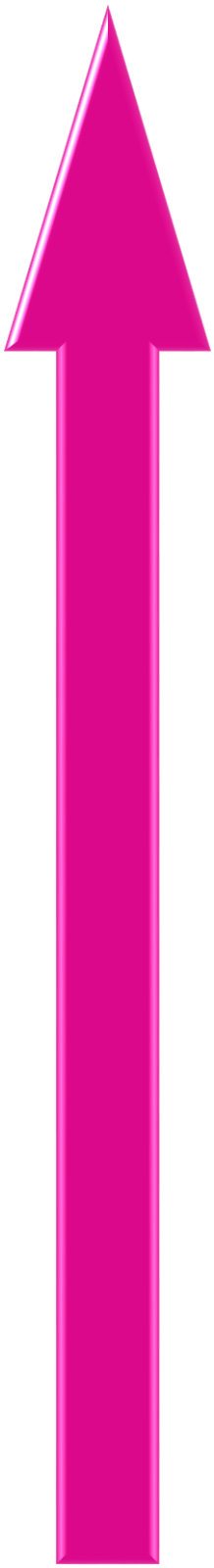
Key achievements:

- Our experienced safeguarding, mental health and learning disability team, who provide an integrated and consistent approach to supporting staff to meet the needs of vulnerable people have remained on site and provided face to face support for patients and staff in both hot and cold Covid19 wards and departments
- Key safeguarding functions have continued utilising digital technologies including the investigation of safeguarding allegations, management of Deprivation of Liberty Safeguards (DoLS), training, supervision, audit, incident investigation and response.
- We maintained our Safeguarding Training compliance with the exception of level 1 child protection training, where we achieved more than 90% against a target of 95%.
- The Safeguarding Team has increased capacity for children protection and learning disability.
- The Safeguarding Team is fully recruited.
- There has been a significant amount of daily interagency partnership working to safeguard children, young people and adults of all ages with cognitive problems due to mental ill health, learning disability, autism and dementia.
- We have supported key Berkshire West Safeguarding Children's Partnership and West of Berkshire Safeguarding Adult Board functions and participated in multiagency 'Operational Safeguarding in Covid' meetings for both children and adults which have allowed us to be agile and responsive to emerging trends.
- We have engaged with multiagency partners to ensure key strategic priorities were progressed including the LeDeR mortality review programme; the Berkshire West All Age Mental Health Crisis Review; ONE Reading Prevention and Early Intervention Partnership Board and work streams and Ofsted/CQC SEND inspections
- We have developed a dedicated safeguarding section and screening for perinatal mental health in our new Maternity Electronic Patient Record (EPR) and progressed work to develop the electronic child safeguarding referrals to support information sharing and a single record.
- Our Risk Based Priorities for 2021/22 have been agreed through the Strategic Safeguarding Committee

None of this would be possible without the professional curiosity, courage and commitment of our frontline staff and the safeguarding team and the support of our senior leaders, managers, executive and board. I would like to take this opportunity to thank them all for their continued support and dedication to safeguarding our patients.

Patricia Pease, Associate Chief Nurse, Safeguarding, Mental Health and Learning Disability, July 2021

2020/21 Safeguarding, Mental Health and Learning Disability Quick Facts:



Adult Safeguarding

- 20% increase in adult safeguarding concerns raised
- 33% increase in DoLS applications

Child Protection and Safeguarding

- 10.6% increase in child protection referrals
- March 2021 - highest month on record for
  - child protection referrals 191
  - referrals to Dingley from local authorities for child protection medicals 28

Maternity Safeguarding

- 10% increase in unborn child protection referrals
- 15% increase in invitations to child protection conferences

Learning Disability

- 12% increase in referrals to Learning Disability Liaison Nurses
- 34% increase in referrals to the LDLN team in the first 3 months of 2021 compared with 2020

Mental Health – Children & Young People

- 5% increase in ED attendance children and young people
- 25% increase in ED attendance 16/17 year olds
- March 2021 - highest month on record for
  - under 16 year olds attended ED 71

Mental Health Act – detentions to RBH

- 18% increase in Section 2 and 3 detentions
- 68% increase in presentations to ED all ages detained on Section 136

1. INTRODUCTION

This report covers all areas of safeguarding, mental health and learning disability work across the Trust and sets out our priorities for further work. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect (NHSE, 2018). Safeguarding at the RBFT is fundamental to high-quality health care. Safeguarding is everybody's responsibility.

1.1. Safeguarding, Mental Health and Learning Disability Structure

The safeguarding, mental health and learning disability structure (nursing and administration) and lines of responsibility and accountability for the RBFT are shown in the diagram below:

Adult Safeguarding Medical Leads:	• Urgent Care Group: recruitment underway • Planned Care Group: recruitment underway • Dr Hannah Johnson: Networked Care Group
Adult Safeguarding Matron Leads:	• Georgie Brown: Urgent Care Group • Erin Jarvis: Planned Care Group • Ali Drew: Network Care Group
Child Protection Medical Leads:	• Dr Ann Gordon: Named Doctor for Child Protection • Dr Andrea Lomp: Designated Doctor Child Protection, Berkshire West, CCG • Dr Aziz Siddiqui: Locality Paediatrician, Children's Safeguarding • Dr Niraj Vashist: Medical Advisor to Fostering and Adoption Panel
Child Death	• Patricia Pease: Designated Healthcare Professional Child Death Berkshire West, CCG
Sexual Health	• Julia Tassano-Edgecombe: Nurse Consultant
Human Resources	• Suzanne Emerson-Dam: Deputy Director Workforce & OD, Designated HR Officer Safe Recruitment & Allegations Management
Legal	• Sarah Pearson: Head of Legal Affiars

The safeguarding, mental health and learning disability service is accountable to the RBFT Executive Management Committee and Board, Berkshire West CCG, Berkshire West Safeguarding Children Partnership (BWSCP), Berkshire West Safeguarding Adult Board (SAB) and participates in Berkshire West and Pan Berkshire Mental Health, Suicide Prevention, Learning Disability, Transition and Mortality strategic partnership meetings.

1.2. Safeguarding and Mental Health Governance Committee Structure

The Strategic Safeguarding and Mental Health Committee, chaired by the Chief Nurse, meets twice a year. The Trust has a non-executive Director, Helen Mackenzie, with a responsibility for safeguarding, mental health and learning disability. The safeguarding, mental health and learning disability team meets monthly to discuss operational issues and prepare performance reports; agendas and minutes are kept for these meetings. Safeguarding, mental health and learning disability quality indicators are reported monthly to the Board. A

bi-monthly safeguarding, mental health and learning disability governance report including key performance indicators is submitted to the Board as part of the QALC report, this report is shared with the Berkshire West CCG Health Partners Strategic Safeguarding Committee. Multi-disciplinary child protection clinical governance is held every two months; chaired by the Named Nurse for Child Protection. Safeguarding Adult Clinical Governance is held every three months chaired by the Safeguarding Adult Lead Nurse. A Safeguarding Legal working group meets every six months, co-chaired by the Head of Legal Services and the Associate Chief Nurse Safeguarding, MH & LD reporting to Adult Safeguarding & Child Protection Committees and to the Strategic Safeguarding Committee. The Associate Chief Nurse, Safeguarding MH & LD chairs a Zero Tolerance, Challenging Behaviour, V&A, Self-Harm, Suicide Steering Group and oversees working groups which reports to the Joint Royal Berkshire NHS Foundation Trust & Berkshire Healthcare NHS Foundation Trust Mental Health & Learning Disability Governance & Partnership Meeting and by exception to the Health & Safety Committee. Monthly Safeguarding Concerns and Allegations Review Meetings are chaired by the Designated HR Officer Safe Recruitment & Allegations Management; live cases are reviewed to ensure timely conclusions. At quarterly Safeguarding Review Meetings closed cases are reviewed in order to identify patterns or themes and actions.

The Associate Director for Children & Young People, Kate Egginton has led on developing a strategy and children and young person's plan that aligns with the work of the Berkshire West ICP Children's Programme Board and through that with the relevant strategic partnership arrangements for 0-24years Special Educational Needs and Disability (SEND) and Children's Trust arrangements in the three local authorities of Berkshire West, Buckinghamshire, Oxfordshire (BOB) Berkshire East, North East Hampshire and Farnham and Surrey Heath (Frimley Health & Care) Integrated Care Systems (ICSs). The Children and Young People Strategy and Delivery Group monitors work streams to benchmark and improve the quality and safety of Trust services for children.

2. STATISTICS/ACTIVITY:

An overall picture of a decrease in patient activity in 2020/21 has been due the impact of Covid19 lockdowns and government guidelines. There were significant reductions in attendance to our emergency department in April – June 2020 followed by a surge and resumption of normal activity. In January – March 2021, during the second lockdown and as elective activity resumed we saw some of the busiest months ever for safeguarding, mental health and learning disability. The decrease in the numbers of adults and particularly those >65 years presenting to ED was most likely due to Covid19 primarily effecting older people and those patients being referred to and managed on the virtual ambulatory covid ward. The Covid virtual ward managed up to 200 patients at the beginning of 2021. The reduction in attendances was primarily through the minor injury pathway due to lockdown. However the number of over 75 years with cognitive issues staying more than 72 hours increased slightly. During the Covid19 pandemic we increased our Intensive Care beds by 300% the largest increase from funded bed base in England. Digital and virtual changes were made to access arrangements for outpatients and our sexual health clinics.

Appendix 1 Indicative Statistics for the RBFT for Information & Background

3. TRAINING

3.1.

Training	Target	Trust
Safeguarding Adults Level 1	90%	91.5%
Child Protection Level 1	95%	90.7%
Child Protection Level 2	85%	93.3%
Child Protection Level 3	85%	85.6%
Enhanced MCA & DoLS	80%	79.7%
Prevent WRAP or equivalent	85%	94.3%

Training is reported monthly to the Board as part of the integrated board report, exception reports are provided to care groups and corporate directorates and automated reminders are sent for all training due to expire, including safeguarding.

During 2020-21 after the suspension of all face to face training as part of our Covid 19 pandemic response, the Safeguarding Team continued to provide face to face case support and learning opportunities in the clinical setting. Child and adult levels 1 and 2 safeguarding training and Level 3 child update sessions were offered on TEAMS and available as e-learning. A Trust annual training plan for child and adult safeguarding, mental health and learning disability for 2021/22 has been agreed a summary can be found in Appendix 1. All Face to face level 3 child safeguarding full days and Maybo pilot training was re-arranged following Executive approval to mix staff from different parts of the organisation and invite external trainers, this was subject to reduced or small numbers in

rooms big enough to allow for social distancing and all other COVID infection prevention and control precautions e.g. temperature check, masks, hand sanitiser. A safeguarding, mental health and learning disability section was developed for the revised Medical Staff Induction Handbook (New Doctors) and other staff.

All training programmes are regularly reviewed to ensure they include learning from serious case reviews and changes to national policy and guidelines.

In 2021/22 there will be a focus on:

- The Emergency and Paediatric Services safeguarding, mental health and LD training
- The application in practice of the MCA, DoLS and best interest decisions
- The training we provide to prevent, minimise and respond to challenging behaviour, violence and aggression
- The training we provide to support our staff emotional health and well-being including REACT® Mental Health Conversation and TRiM training
- LD/ASD training to support a consistent response to an LD flag or diagnosis 24/7
- Domestic abuse, neglect and self-neglect, prevent/exploitation and concerns and allegations management
- Staff understanding the impact of adverse child hood experiences as part of the RBFT becoming a trauma informed organisation
- Professional curiosity, risk assessment, professional challenge and escalation will continue to be included in all of our safeguarding, mental health and LD training

Appendix 2 Summary of Training Activity 2020/21 and Plans for 2021/22

Ongoing training challenges / risks:

- The flexibility and functionality of the electronic platform used to record and report safeguarding training
- Reduction in face to face training opportunities due to Covid19 restrictions
- Reduced capacity in full level 3 child protection training full day due to Covid19 restrictions, leading to a risk of not achieving the Trust standard for new starters of completing within 6 months.
- Availability and provision of adult level 3 training to comply with the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff, 2018 by the next iteration in 2021.
- Availability of training to comply with the standards of the Restraint Reduction Network Training Standards, 2019.
- Consistency of knowledge and confidence to apply the Mental Capacity Act, DoLS and best interest assessment training in practice
- Training compliance of all of our staff in the aspects of safeguarding, mental health, learning disability and autism training relevant to their practice.
- Consistency of knowledge, competency and professional curiosity in practice.
- Consistency of recognition and assessment of risk and confidence of our staff to respond to a significant increase in case and system complexity
- Availability and consistency of transition to adulthood training
- Availability of specific domestic abuse training outside of maternity services.
- The need for our staff to have knowledge of and understand Contextual Safeguarding, Trauma Informed Care, Adverse Child Hood Experiences and Think Family.

4. AUDIT AND QUALITY ASSURANCE

The Safeguarding Team reviews and updates Trust Safeguarding and Mental Health policies and procedures. They also coordinate an agreed audit program that includes single and multi-agency audits monitored through our internal governance systems and QALC. External scrutiny and challenge is provided through Berkshire West CCG, Health Partners Strategic Safeguarding Committee, the performance sub group of the Safeguarding Adult Board and the Independent Scrutiny Groups of the Safeguarding Children Partnership. We actively participate in the sub groups of the Safeguarding Children Partnership and Safeguarding Adult Board. Through participation our Safeguarding plan is constantly monitored, renewed and updated. The Joint RBFT/BHFT Mental Health and Learning Disability Clinical Governance Committee monitor Mental Health and Learning Disability related standards and audits. In March 2021 we submitted data and information to NHSE & NHSI - Learning Disability Standards Benchmark Review.

Key Areas of Work for 2021/22

In September we will complete and submit our Bi -Annual Safeguarding (children and adults) self- assessment which includes our Section 11 of the Children Act 2004 audit to BWCCG.

Ongoing audit and quality assurance challenges / risks:

- Capacity of the safeguarding team to respond to new multiagency audits.
- Capacity of the safeguarding team to write new policies and procedures
- Capacity of the safeguarding team to complete new NICE/NCPOD assessments in a timely manner.

5. SAFER RECRUITMENT AND ALLEGATIONS MANAGEMENT

Key Achievements

- Responding to/managing/progressing safeguarding concerns and allegations during the Covid-19 pandemic.
- Identification of key themes from safeguarding concerns and allegations in order to communicate lessons learnt from safeguarding cases.

Summary of Cases

In the financial year 2020/21 a total of 20 cases were referred to the Safeguarding Team; 16 cases relating to vulnerable adults and 4 cases relating to children. Of the 20 cases referred 12 were classified as allegations whilst the remainder were classified as concerns. Most of the concerns/allegations related to Trust employees however the concerns/allegations also related to an NHSP worker, a volunteer, a contractor and an agency worker. The safeguarding concerns/allegations were mainly in Urgent and Networked Care. Two concerns/allegations were within the Estates and Facilities Directorate and one in Planned Care, with Volunteers and Other. The main categorisation of concerns/allegations were physical e.g. rough handling of patients and transferrable risk. The outcome of cases was evenly split between no-case to answer; lessons to be learnt and case to answer; to be dealt with as a HR matter. There has been a small increase in the number of cases compared with previous years 18 in 2019/20 and 19 in 2018/19.

Key Areas of Work for 2021/22

To resume normal activity for safer recruitment and the management of safeguarding concerns/allegations following Covid-19 pandemic. This includes:

- To re-instate the Monthly Safeguarding Review Meetings to go through all “live” cases to ensure timely conclusion.
- To re-instate the Quarterly Safeguarding Review Meetings closed cases are reviewed in order to identify patterns or themes and actions identified as a result of identified themes.
- To increase safeguarding awareness amongst Employee Relations Team and other teams as appropriate.
- To further develop relationships with partners e.g. the LADO’s and Thames Valley Police.

- To review our internal processes and training for investigators in light of lessons learnt during the Covid- 19 pandemic

6. CHILD PROTECTION AND SAFEGUARDING

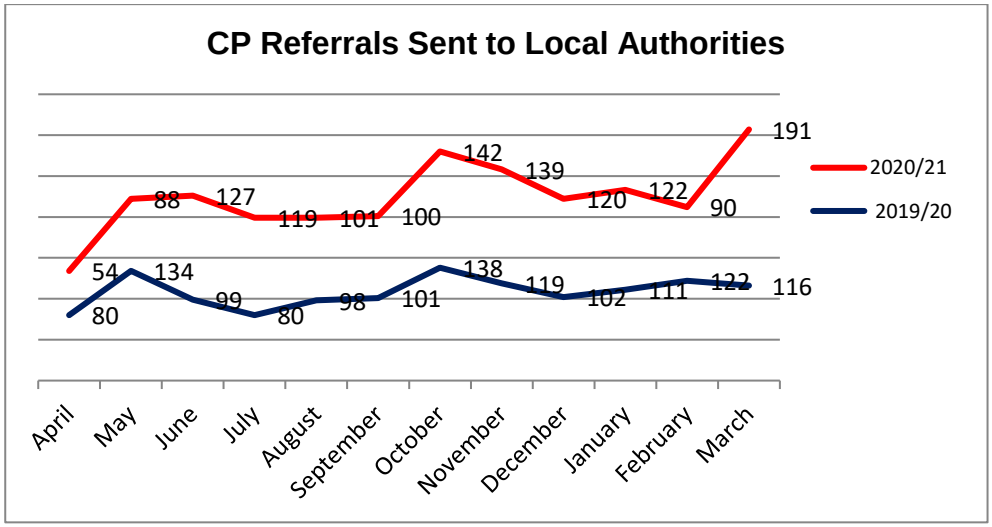
Key achievements

- Child protection has been busy with more complex cases presenting. The Named Nurse Child Protection (NNCP) works closely with frontline practitioners and partner agencies to ensure that the child remains the focus, is safely managed and discharged from our wards and other services.
- The Named Nurse and Midwife have worked closely with partner agencies, meeting them monthly to discuss cases and operational issues. Having liaison meetings builds relationships with the local authority (LA) teams for joint working. The meetings for unitaries in Berkshire West are established, consistent and they have proven invaluable during Covid19.
- Referrals to our three key LAs have been audited for clarity, quality and voice of the child. All audits show that referrals made are clear, with concise decisions around safeguarding children. Where issues are identified, reflection with practitioners enhances practice.
- Child protection level 3 training has continued, despite Covid19. All 1 hourly updates are now virtual. The full day was delivered face to face in October 2020 and will be delivered three times in 2021/22.
- A Paediatric Associate Specialist and the NNCP launched safeguarding debrief sessions for the multidisciplinary team to provide a safe space to reflect on complex cases and learn.
- 1:1 supervision continues for staff who work with highly vulnerable children and families, these include, the paediatric diabetes team, poppy team and sexual health advisors.
- Peer review is offered to Radiology and the Emergency Department. The NNCP will be offering supervision to senior nurses within Paediatrics in 2021/22.
- Child protection Clinical Governance meets bi-monthly, reviews all areas of safeguarding children and is well attended.
- RBFT have been involved in a significant number of complex partnership and serious case reviews which have required full chronologies, analysis of practice and actions in response to recommendations.
- The NNCP attends the Reading Independent Scrutiny group and the Case Review sub group of the Berkshire West Safeguarding Children Partnership.
- Work progressed with Information Management and Technology (IM&T) to develop the electronic child safeguarding referrals to support information sharing. All child protection information is now uploaded to the Electronic Patients Record to support a single record and enable staff to have a better understanding of individual children's safeguarding issues.
- The NNCP has worked closely with frontline practitioners in Paediatrics and Emergency Department to raise safeguarding skills and confidence. Safeguarding champions have been identified in the Paediatric Wards and Departments and in the Paediatric Emergency Department. The champions are meeting regularly with the NNCP to strengthen safeguarding practice.
- The Named Nurse and Named Midwife for Child Protection support staff in the Special Care Baby Unit to identify babies who are admitted under social care, monitor babies and families that may need further support and ensure safe discharge.
- Capacity within Child Protection team had been highlighted as a risk due to the high numbers and complex cases presenting. Funding was secured for 1 WTE band 7 Child Safeguarding Clinical Nurse Specialist. An experienced applicant was recruited and appointed, start date May 2021.
- Brighter Futures for Children have secured funding for 1 year for a Hospital Early Help Worker 0.6 WTE to work within the safeguarding team and alongside frontline practitioners, primarily with maternity, paediatrics and paediatric ED. The post was recruited to and started in Q1 2021/22.

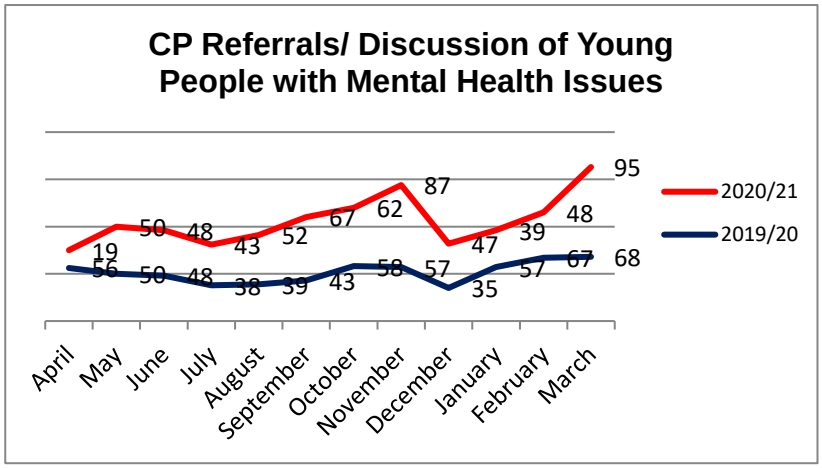
- A Volunteer Navigator Service developed during 2020/21 has started in to our Emergency Department (ED). This has been funded through Thames Valley Police Violence Reduction Unit. Starting Point, a third sector organisation has been commissioned to provide and co-ordinator the service. The aim of the Navigator Service is to provide mentoring to supporting young people aged 13–24 who attend ED journeying with them to access support within the wider community.

Key concerns

- We have seen an increase in activity and a significant increase in complexity of cases from both a safeguarding and a psycho-social context in relation to needs of specific patient groups:
  - pregnant women, unborn babies and babies under six months
  - children and young people from troubled families
  - children and young people with complex mental health presentations particularly eating disorders, disordered eating and neurodiversity
  - children and young people with a learning disability and autism
  - adolescents presenting and admitted with risk taking behaviours, including injury due to violence
  - drug and alcohol presentations and cases involving domestic abuse
- The safeguarding and safe discharge of babies and children who have been abused and children and young people with mental health needs admitted to the RBH is monitored closely by the Safeguarding Team
- On-going work with frontline practitioners around the interface liaison and discussion with children's social care and CAMHS remain a challenge, especially for 14 – 17 year-old inpatients.
- Covid19 has and will continue to have a huge impact on children and families socially and economically. The impact for RBH has and will be seen in the complexity and vulnerability of child protection cases presenting to practitioners at the frontline and the safeguarding team
- The capacity of the NNCP and child safeguarding team to support the demand for level 3 training, the Rapid Review and learning process and the number and complexity of cases presenting to RBH. These cases require longer admission, more multiagency meetings and the use of the escalation policy internally and externally to partners to ensure the safety and safeguarding of children & young people
- The increase in the number of requests from the Local Authority Joint legal Team for notes or statements for family court proceedings and the increase in children on child protection plans in Berkshire West has and will continue to result in significant pressure on the capacity of the Safeguarding Administration Team.



2018/19 – 1045 referrals, 42% increase
2019/20 – 1300 referrals, 24% increase
2020/21 – 1438 referrals, 10.6% increase
COVID impact - April/May 2020 44% reduction compared to same period 2019



2018/19 – 573 referrals/discussions, 12% increase
2019/20 – 616 referrals/ discussions, 7.5% increase
2020/21 – 657 referrals/ disccusions, 6.65% increase
COVID impact April/May 2020 35% reduction compared to same period 2019

Key Areas of Work 2021/22

- Continue to respond to emerging child protection and safeguarding trends and themes due to the psycho-social impact of Covid19 on the most vulnerable children, young people and families
- NNCP will continue to offer supervision/ reflective sessions for all Paediatric and Emergency Department staff as part of their level 3 child protection updates.
- NNCP will work closely with senior nurses in Paediatrics to ensure knowledge and skills are embedded in their practice, alongside the safeguarding champions.
- To continue to audit referrals made to each Local Authority within Berkshire West to ensure that good, clear and concise referrals are being made for children.
- To continue to monitor young people who attend and are admitted to the RBH with mental health needs, conduct disorders and particularly eating disorders and work closely with the clinical teams, Lead Nurse for Mental Health and all partner agencies.
- Utilising a dashboard developed from the Emergency Department electronic patient record the NNCP will progress a weekly review and liaison group that will include a Consultant Paediatrician, Senior Paediatric ED Nurses and an ED Consultant to retrospectively scrutinise the admission notes of babies under 6 months presenting with an injury. The group will ensure that all safeguarding processes were followed and that the explanation for the mechanism of injury was credible. This is in response to learning from incidents.
- Review all competencies for band 5 and 6 paediatric nurses against, The Royal College of Intercollegiate Document and identify training needs.
- Review the pathway of safeguarding processes and communication from paediatric ED to paediatric wards
- Work with BHFT to establish a Band 7 Health Visitor to work with Buscot to support improved discharge planning for vulnerable babies and families.

On-going child protection and safeguarding challenges / risks

- RN nurse vacancies and permanence on Paediatric Wards and ED, safeguarding skills and experience of practitioners in managing complex cases.
- A small group of child and young people 'frequent attenders' who are high profile in terms of self-harm, complex psychosocial issues, significant mental health concerns, including eating disorders and increased length of stay.
- The numbers of children and young people with mental health problems at risk from self-harm and suicidal ideation attending the Emergency Department.
- < 16s admitted to the paediatric unit and 16/17 year olds to ED Observation Bay, Acute Medical Unit or Short Stay Unit detained under the Mental Health Act requiring admission to Tier 4 Child and Adolescent Mental Health, Eating Disorder or Conduct Disorder services and delayed in the Royal Berkshire Hospital.
- The Trust does not have an adolescent or young person service model or facility to consistently support aged 14-18 years who are either admitted to a paediatric or adult ward
- Capacity of the NNCP and child safeguarding team to manage the increase in activity and complexity. To mitigate risk by supervising, challenging and escalating. To participate Berkshire West Safeguard Children Partnership groups, Case Reviews for children that have been discussed at the Berkshire West case Review group to deliver training and internal and external governance responsibilities.
- While Covid19 continues to challenge all services, the greatest safeguarding risk will be to children and young people and ensuring a robust approach to protecting them from harm remains a high priority.

7. MATERNITY CHILD PROTECTION

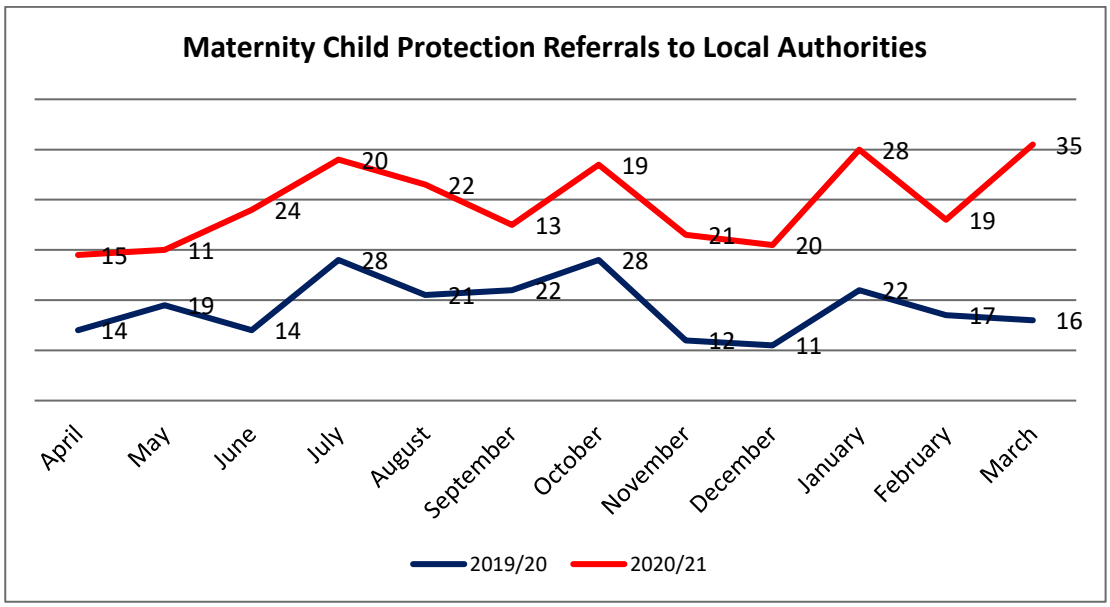
Key achievements

- In response to the rise in non-accidental injury during lockdown the NMCP, NNCP the Director of Midwifery, the Head of Safeguarding Children BWCCG and Lead for Community Children's Services, BHFT worked together to monitor midwifery to health visitor notifications and develop a joint flow chart for antenatal and post-natal midwifery and health visiting face to face and virtual contacts. This was shared with local authority partners. In Reading the established pre-birth team partnership model quickly incorporated a case discussion 'panel' with midwifery input.
- Additionally our midwifery team introduced a telephone contact call to partners on day 7 to explore challenges and stresses they may be experiencing as new parents, isolated from extended families using the icon material https://iconcope.org/ and included a discussion about safe sleeping. This is still in place and used as another opportunity to explore vulnerabilities and work with families to improve outcomes for children.
- Liaison meetings with Reading's Pre-birth Team became well established during 2020/21, working intensively with the most vulnerable mothers to improve the outcome for families. One of the aims is to reduce the number of babies going into foster care whilst ensuring the baby is safeguarded and the family fully supported to care for baby. The Poppy and Safeguarding teams worked very closely with the Pre-birth Team.
- The NMCP and NNCP, the Poppy Team and Director of Midwifery worked closely with each other and with the Head of Safeguarding Children BWSCP to ensure appropriate safeguarding supervision for midwives working with vulnerable women and families to respond to emerging safeguarding issues during lock down.
- Midwives continued to provide a RAG rated face to face antenatal and postnatal visits with appropriate PPE
- NMCP has been involved in identifying opportunities to talk to women face to face and alone about domestic abuse during pregnancy and providing additional training for staff
- NMCP has been involved in reviewing practice in the cases of the death of one baby and serious injuries to three babies referred to the National Child Safeguarding Practice Review Panel requiring a Rapid Review

- Child protection for the unborn, new born babies and vulnerable parents have been busy with more complex cases. The Named Midwife for Child Protection (NMCP) works closely with frontline practitioners and partner agencies to ensure that the unborn and new born remains the focus and is safely discharged.
- NMCP works closely with partner agencies to ensure that the safeguarding needs of the unborn, new born and vulnerable parents are met, appropriate plans put in place and carried out.
- Liaison meetings are held with Wokingham, West Berkshire and Reading local authorities these are usually bi-monthly.
- Vulnerable women's meetings are held monthly with representatives from Health Visiting, Perinatal Mental Health, Sexual Health and Poppy teams and Reading Multiagency Safeguarding Hub (MASH).
- The Poppy Team supports our most vulnerable families; the NMCP works closely with the Poppy team and supports them in their practice. NMCP provides training and support to ensure they are aware of the unique role and responsibility of being a Poppy Team Midwife.
- Community midwives are now providing care to women living in East Berkshire who wish to deliver at RBFT; this has increased the work load of the NMCP. It requires the NMCP to participate in out of area conferences and multidisciplinary meetings as well as supporting staff to complete written reports.
- The Domestic Abuse Policy has been reviewed and updated.
- Maternity Services went live with EPR November 2020; there was a smooth transition from paper records to electronic records. The Named Midwife spent a significant amount of time prior to going live to make sure all aspects of safeguarding were mapped and considered. Since introduction there have been no significant incidents where information was not shared or a new born on Child Protection Plans was discharged without the necessary discharge planning meetings taking place. The implementation of EPR into maternity services has been a positive change and a good example of staff working together to improve communication and safety.
- NMCP has:
  - Worked with Brighter Futures for Children, to write new Pre-birth Protocol and attended a workshop with Wokingham Local Authority to look at their Early Help strategy
  - Attended the BWSCP learning and development subgroup providing feedback on training needs and ensuring that our training continues to be of a high standard, meeting BWSCP and national requirements
  - Provides supervision for the Poppy team.
  - Provided newly qualified midwives with on the job support concerning their safeguarding practice, teaches on the preceptorship day and provides additional safeguarding training sessions for Community Teams
- During Covid 19 all of these established pathways, groups and relationships have proven invaluable.

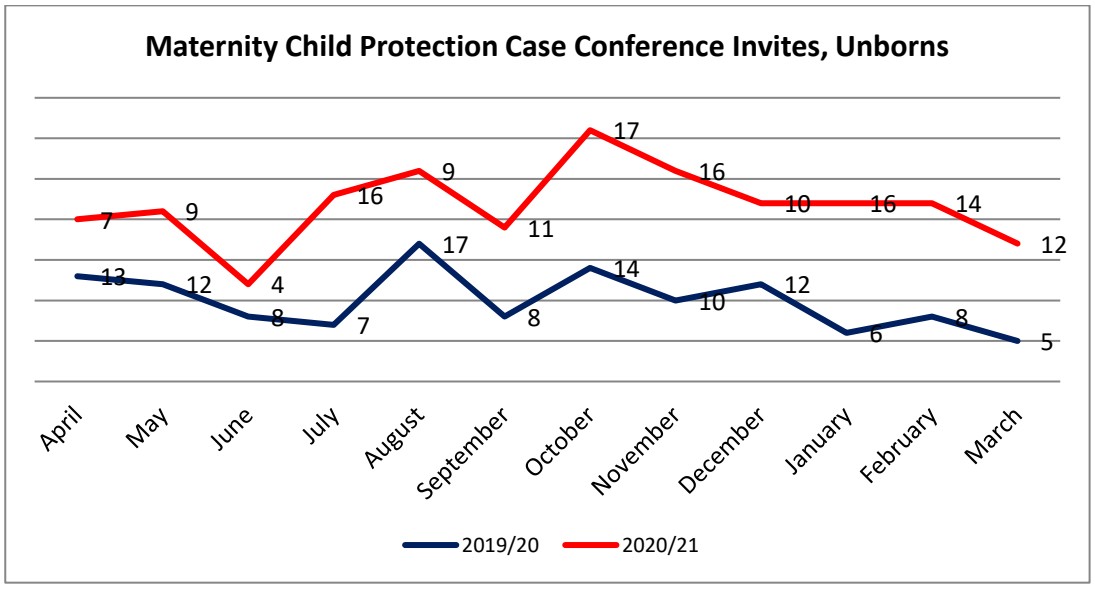
Key concerns

- The on-going impact of Covid19 on the most vulnerable families and emerging safeguarding trends and themes seen in maternity services.
- The capacity of the Named Midwife to support the number of complex of cases identified within the Maternity Services. These cases require intense scrutiny, more multiagency meetings and the use of the escalation policy internally and externally to partners to ensure the safeguarding and safety of the unborn and new born
- Increased demand for level 3 training in maternity services and the Rapid Review and learning process when a baby has suffered significant harm.
- Capacity to support the NNCP in delivering Trustwide level 2 and 3 child safeguarding training and level 3 up dates
- Band 5 Midwives continue to rotate to the community, this gives them an overview of the community and improves their understanding of all aspects of Maternity services, it is challenging for the safeguarding team to ensure that new community midwives have the necessary skills. The NMCP attends the study day for new community starters at each rotation change.



2018/19 – 219 referrals 1% increase from 2017-2018
2019/20 – 224 referrals 2% increase
2020/21 - 247 referrals 10% increase
Of the 247 referrals made by Midwives to the three Local Authorities in 2020/21:

- 60% were to Reading, Brighter Futures for Children compared to 50% in 2019/20
- 20% were to West Berkshire CSC, compared to 30% in 2019/20
- 15% were to Wokingham CSC, compared to 18% in 2019/20
- 5% were to our neighbouring local authorities which remained the same as 2019/20



2017/18 – invitations 130
2018/19 – invitations 146, 12% increase
2019/20 – invitations 120, 18% decrease
2020/21 – invitations 141, 15% increase

We were able to attend 126 (89%) this is 11% increase on 2019/20. The majority of conferences that were not attended were post-delivery when Maternity no longer had an input with the family.

We provided reports for 126 of the conferences this is 90% this is a decrease from 98% in 2019/2020, but consistent with 92% in 2018/19.

- 50% were in Reading compared with 51% in 2019/20
- 28% were in West Berkshire compared with 26% in 2019/20
- 16% were in in Wokingham this is consistent with 16% in 2019/20
- 6% were for neighbouring authorities this is down slightly from 7% in 2019/20,

7.1. Local Authority Vulnerable Person figures for 2020/21

Vulnerabilities are identified as: learning disabilities, domestic abuse, child protection concerns, significant mental health issues, drug and alcohol misuse, homelessness, FGM, teenager, concealed pregnancy, trafficked women and if mother of a baby was identified as a 'Looked after Child'.

Due to the changes in data collection with the implementation of Maternity EPR during the 2020/21, collecting these figures in total and by local authority has not been possible they will be included in the 2021/22 report.

Forward planning 2021/22

- In 2021/22 additional data will be collected and reported monthly through the Integrated Board Report to capture the complexity within Maternity services this will include:
  - Child Safeguarding concerns raised by maternity
  - Unborn on CP/CIN plans
  - Number of women reaching poppy team criteria (referrals)Babies born with CP/CIN plans
- Brighter Futures for Children have employed an Early Help worker to work within the Trust, with the aim to reduce referrals into their Children's Single Point of Access (CSPOA) by 40%. The worker is supported by the Safeguarding team and will initially work within Maternity Services and then provide support for Paediatric and Accident and Emergency units.
- Continue to respond to the on-going impact of Covid19 on the most vulnerable families and emerging safeguarding trends and themes seen in maternity services. Although lockdowns are being lifted the long term impact on Mental Health of parents will potentially have a significant impact on Maternity services for several years.
- Continue to provide newly qualified midwives with on the job support concerning their safeguarding practice. Teaching on the preceptorship day and the new community Midwives starters' day.

Ongoing maternity child protection challenges / risks:

- Increase in complexity of cases of at risk families, unborn and new born babies
- Capacity of the Named Midwife to support the number of complex of cases, attend multiagency meetings, meet the increased demand for level 3 training and the Rapid Review and learning process when a baby has suffered significant harm, provide 1:1 safeguarding supervision to the Poppy Team and support safeguarding practice for the increasing number of newly qualified midwives throughout their rotation.
- Capacity of Poppy Team midwives to write reports and pressure on the Poppy Team and the NMCP to attend child protection conferences, the Poppy Team also provide intra partum care for some of the most vulnerable women
- Increase in the number of Strategy meetings held; these are usually held with only 24 hours' notice and discharge planning meetings.
- Community midwives providing care to women living in East Berkshire increasing the workload of the NMCP, presenting logistical challenges regarding continuity of care and liaison with new partner agencies.
- Maintaining maternity staff compliance Level 3 Safeguarding Children Training.
- While Covid19 continues to challenge all services, the greatest safeguarding risk will be to unborn and new born babies and vulnerable parents and ensuring a robust approach to protecting them from harm remains a high priority.
- Ensure that EPR continues to capture the appropriate safeguarding information that can be easily accessed by staff.

8. MATERNITY MENTAL HEALTH

Perinatal mental health continues to be a focus for service development and staff education in line with the recommendations of national drivers such as Better Births and the Long Term Plan:

Key achievements:

- The provision of Perinatal Mental Health training for the multi-disciplinary team has continued to be a challenge this year. Traditionally the Berkshire Perinatal Mental Health Team (BPMH) provide training, however due to resource issues BPMH have not been able to offer their usual support. Face to face training has remained limited due to Covid-19 precautions. Training is virtual using a national training package hosted on Learning Matters, scenarios relating to maternal mental health continue to be part of our in-house multi-professional emergency training. This has been well evaluated by midwives.
- There is a new screening specialist midwife in post, in response to learning from a serious incident the foetal abnormality service has been reconfigured to better support women found to have a foetal abnormality.
- The joint perinatal mental health and obstetric clinic continues with the Berkshire Perinatal Mental Health Team. The clinic is due to be expanded, with agreement for additional Consultant Obstetric time for an extra two clinics per month (from 2 to 4 clinics). We are currently scoping and banding additional midwifery time to support this clinic, as a joint integrated role with the Poppy team. The aspiration to commence the expanded clinic in summer 2021 has been on-hold due to staffing issues from the BPMH service. It continues to be a shared aim of both Trusts to support this service. Thanks to Consultant Obstetrician Anna Ashcroft who has been leading this clinic for Sunetra Sengupta during her leave of absence.
- The Birth Reflections Pilot has finished and agreement reached for it to become an established part of our service offer. Demand has been exceptional, with waiting times up to 4 months in 2021. The majority of women were first time mothers who wanted to better understand the events of their birth. Any emerging themes from the clinic are fed back to the Intrapartum Strategy Group where solutions are identified. Feedback received about individual members of the team are passed directly to those identified and star cards sent when appropriate. We are addressing the long waiting times and the demand for the service by advertising for a Band 6 Birth Reflections midwife, to work alongside our existing Band 7 Birth Reflections lead midwife. This will increase capacity from 4 to 12 appointments per week.
- Screening for perinatal mental health has been included in digital work relating to antenatal and postnatal care in the Maternity Services Electronic Patient Record move to Cerner.

Forward planning for 2021/2022:

- Continue to respond to the emerging evidence of the impact of Covid19 on the perinatal mental health of parents. We have worked very closely with the Maternity Voices Partnership user group to plan, communicate and adapt our Covid-19 restrictions on partner/birth partner support, to facilitate the maximum support for families within what is safe from an infection control. Individualised plans for additional birth support/overnight stays have been made on a case by case basis, especially for women with mental illness.
- Continued work with Maudsley Learning to achieve accreditation for our Perinatal Mental Health Training remains paused due to Covid-19.
- Expansion of continuity of midwifery care teams continues to encompass women with significant mental illness. The Poppy Team on-call model has been paused/restricted during Covid-19 but with additional midwives to the team, this is looking to be reinstated soon. The Blossom midwifery team also picks up women from postcodes with higher complexity in their physical, social and psychological needs.

9. FEMALE GENITAL MUTILATION (FGM)

Key achievements

- NMCP provides FGM figures on a quarterly basis to the BWSCP.

- The Trust is fully compliant with adding FGM-IS information to the National Spine; the safeguarding team is responsible for submitting that data.
- An FGM referral pathway has been agreed with the local authorities to ensure appropriate/proportionate information is being shared.
- During Covid:
- The internal RBFT pathway for women with referrals to a to a Specialist Obs/Gynae Registrar has continued
- It was not possible to maintain the face to face element of the Reading Rose Centre, however a virtual service was offered by other women's charitable organisations 'Utulivu' and 'Women with Vision'
- Additionally a specialist midwife Jammie Korama has offered a service to women

Activity

- Maternity – 25 cases identified, which is up 8 from last year. All of those had appropriate referrals to children's social care.
- 22 cases were identified antenatally with the remaining 3 cases being identified at delivery. Two women did not disclose FGM and continued to not acknowledge they had had FGM performed as they had not been informed by their families, with the remaining woman it is not clear why it was not identified antenatally, however once identified appropriate referrals were sent to the relevant Children's services. 17 were reported to Reading, 7 to Wokingham and 0 to West Berkshire. One referral was made to a neighbouring local authority.
- There were 12 further referrals to local authorities at delivery when the infants were female. 9 referrals were made to Reading, 3 to Wokingham, 0 to West Berkshire or neighbouring Local Authorities.
- Gynae/sexual health – 1 case reported – NB case identified had already been reported by maternity.
- Paediatrics 0 cases reported.
- General Trust – 0 cases reported.

Key areas of work for 2021/22

- Partners involved in the Rose Centre will meet to plan to reopen a face to face service

10. CHILD PROTECTION AND SAFEGUARDING CHILDREN AT DINGLEY CHILD DEVELOPMENT CENTRE (CDC)

10.1. Child Protection Medicals

Dingley provides a service for child protection medicals (CPM), referrals come from social services this has continued during Covid19 and has been kept under review by the Clinical Lead and the Named Doctor for Child Protection. Initially during lock down there were no referrals that trend has reversed.

Key Achievements

Following concerns raised by children's social care about delays in medical assessments and the challenge of an unpredictable referral pattern across the week, the CPM process was reviewed.

- Introduction of a Child Protection bleep and telephone for direct referrals
- Introduction of 2 administrative coordinators for child protection referrals, to provide consistency
- Introduction of an online referral form that is completed by the social worker
- Introduction of a full- time day cover by a Registrar who does not have clinic commitments
- These improvements have led to a more robust referral system and eliminated avoidable delays by :
  - Increasing the quality of referral information
  - Providing the paediatrician with more accurate information and history.
  - Facilitating a fuller discussion and more accurate understanding of the social context and history of the family
  - Improving the relation between the Dingley Team and referring social worker

10.2. Child Protection (CP) Peer Review Meeting

During 2020/21 Dingley established a monthly Child Protection Peer Review Meeting. This was in response concerns around safeguarding practise in the department which triggered a review by the Trust`s Safeguarding Team. Establishment of a Peer Review Meeting was one of the recommendations. The meeting is now well established and provides assurance that the case findings and reports meet national standards. The meeting is attended by all Community Paediatricians, Registrars and the Named Doctor and /or Nurse for Child Protection. Cases during the previous month are discussed. The peer review meeting provides a proactive culture of learning, and professional development that comply with new RCPCH 'Good practice service delivery standards for the management of children referred for child protection medical assessments' published in October 2020.

10.3. Child Protection Network Meeting

Bimonthly meeting via TEAMS for Clinicians, Therapists, Chaperones, Social Workers and CP coordinators to discuss cases, obtain feedback on outcomes, escalate concerns and discuss process.

Challenges/risks

- Non urgent child protection medicals being provided at a site remote from the RBH
- Covering child protection medical rota which is dependent on paediatric registrar provision from the deanery
- An increase in the number of child protection medicals after the Covid19 lockdown lifted and children returned to school, with 28 referrals in March 2021.

Forward planning 2021/22

- Complete and embed a Child Protection Medical audit to evaluate the reviewed service

10.4. Locality Paediatrician

Dr Aziz Siddiqui, Consultant Community Paediatrician has taken on the role of locality paediatrician for Children's Safeguarding this includes:

- Providing medical input in West Berkshire Independent Scrutiny & Impact Group meetings
- Supporting Child Protection teaching and training
- Participation in Rapid Reviews
- Working with the Child Protection and Safeguarding teams to ensure key messages are communicated

10.5. Child Looked After Children (LAC) and Fostering and Adoption

Medicals for children who are being fostered and adopted and the role of Medical Advisor to the Fostering and Adoption Panel are provided by Dr Niraj Vashisht, Community Paediatrician.

Forward planning 2021/22

Complete a case audit to evaluate the service

11. CHILDREN WITH SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND)

Key Achievements

Maintaining the service and developing new ways of working during Covid19 pandemic.

11.1. Education and Health Care (EHC) plans

- Early notification to local authorities (LAs) of possible child with SEND
- As a result of close working with LAs to improve SEND provisions across Berkshire West to improve the timeliness of Education and Health Care (EHC) plans a new process is embedded and we have increased our compliance from 30% to 100%
- Time for Clinical contribution to complex EHC discussion are now featured in consultant job plans

- Improving the quality of our targeted contribution to EHC process by establishing a EHC contribution template

Forward planning 2021/22

More work to strengthen quality of targeted contribution to the EHC process

11.2. Epilepsy Service

- **E-QIP 2019-2020**
  - The RBH epilepsy team were one of 11 teams from across the whole of the UK selected for an RCPCH project looking at developing Quality Improvement Projects for Children and Young People with Epilepsy.
  - This involved 6 members of the team attending a weekend course November 2019 followed by the development of a project, which was presented at National Level.
  - We have set up a 'First Fit' phone call service for CYP attending ED with their first fit, with the Epilepsy Nurses.
  - This has confirmed the need for reinforcement of safety information to families, as it is difficult for them to take the information in when in ED.
  - It has also flagged the need for some of these young people to fast track to Paediatric Epilepsy Clinic.
  - Following on from this, the team have employed similar strategies to work on better surveillance and support of the mental health needs of those with Epilepsy.
- **NICE Epilepsy 2019-2022**
  - Dr Sarah Hughes, Paediatric Consultant Neurologist is a committee member on the NICE panel looking at Epilepsy management in Children, Young people and Adults.
  - This is due for publication in Feb 2022.

11.3. Transition of Young People with Neurodisability and/or Epilepsy to Adult Services

- Young people with Neurodisability and Epilepsy have a robust service transitioning through to adult services that is stable, with regular clinics running.
- Information sheets were produced this in 2020/21 to ensure that is equity of information shared by the team.
- This has been shared with BHFT teams and with Reading and Wokingham Local Authorities. Representation was made to the Wokingham transition working group during 2020.

11.4. Multiagency Level 3 Training run for BWSCP – Safeguarding Disabled Children

- In 2020 Dr Sarah Hughes, Paediatric Consultant in Neurodisability arranged and led a multiagency Level 3 Safeguarding Disabled Children training day for BWSCP.
- This one-off single day training course was run by a multiagency group of presenters including a Senior Manager in the Disabled Children's team at Brighter Futures for Children, Reading the Designated Professional for Child Death, BWCCG and Reading LADO (Local Area Designated Officer)
- We had around 50 attendees, from a wide variety of backgrounds to consider safeguarding in its broadest context for our most vulnerable children and young people.

11.5. Thames Valley Network Hospital Communication Passport 2020/21

- Members of Dingley CDC and Oxford Community teams worked together on a project with families to develop a communication passport for use across Royal Berkshire and John Radcliffe Hospitals.
- This is available on the RBFT website and can be completed by families to ensure that their young people's needs are well recognised within the hospital and outpatient settings.
- By working together, children can use the same documentation across a number of different settings, to reduce the difficulties that can arise with communicating a child/young person's needs.
- This has been rolled out across the paediatric wards at the Royal Berkshire and John Radcliffe Hospitals.

11.6. Downs Syndrome Clinics

- During 2020/21 we have reviewed the Downs Syndrome Clinical Pathway and Guidelines.
- This has been In collaboration with the Neonatal team, GP`s, Community Paediatricians and the Neurodisability Nurse
- The aim is an early involvement of the specialist multidisciplinary teams including as Speech and Language Therapists and Physiotherapists

Forward planning 2021/22

- A unique pathway and guideline is being developed that carries through the patient`s life span (from neonate to adulthood)
- Joint Down's Syndrome clinics led by a Consultant Paediatrician and a Neurodisability Nurse planned at Dingley CDC from August 2021
- The Neurodisability Nurse will work closely with the community and general paediatricians and therapists to run the Nurse Led Downs Syndrome Clinic.
- The Neurodisability Nurse role includes:
  - Medical and developmental assessment of all < 5-year-old children with Down's Syndrome referred to the Downs Syndrome Clinic
  - Arranging investigations and making referrals to different therapies and departments.
  - Giving information and providing support to the family

Ongoing challenges / risks child protection and safeguarding at Dingley Child Protection Centre:

- Covering of the Child protection rota
- Increase in the number of child protection medicals after the covid lockdown and children returned to school - 28 referrals in March 2021
- More work needs to be done to strengthen quality of our targeted contribution to the EHC process

12. CHILD DEATH

Thirty three children and young people < 18 years' resident in Berkshire West died 01/04/20 -31/03/21

Seventeen of those deaths were unexpected requiring a joint agency response (JAR)

A joint agency response was triggered following the death of a care leaver who was 18 years and 6 months old.

1. **Twenty two of the deaths were in the neonatal period.**
   - Seven of the deaths were unexpected and reviewed through the Joint Agency Review process
   - Awaiting confirmation concerning one neonatal death/stillbirth
   - In response to the balance of neonatal deaths among the overall numbers of child deaths reviewed, the Pan-Berkshire Child Death Overview Panel (CDOP) has established a specialist panel
   - Neonatal deaths are reviewed annually for the calendar year and thematic learning and actions reported to CDOP
   - The panel met for the fourth time in June 2020 to review all neonatal deaths in the period 01/01/2019 – 31/12/2019 and share the learning. This meeting was originally scheduled for March 2020 but due to Covid-19 was rescheduled to later in the year
   - For the first time colleagues from the John Radcliffe Hospital, Oxford and the Child Mortality Team from OUH (Oxford University Hospitals) joined the panel
   - Clinical learning for these highly complex cases has been shared in detail with clinical staff
   - The panel noted the following points of good practice whilst carrying out their review:
     - Extensive reviews were undertaken with good clinical representation

- There was good antenatal planning with detailed plans for different possible outcomes when abnormalities were possible
- A Key Worker was identified early on and involved throughout when needed
- Excellent nursing care noted
- Parents' views were listened to and there was involvement in all care choices
- Good use of multi-disciplinary teams

- The panel met in in April 2021 to review neonatal deaths in 01/01/20 – 31/12/20

2. Twelve of the deaths were in children (infants, children and young people)

- Two child deaths were expected, both died in hospital
- Ten of the child deaths were unexpected and reviewed through the Joint Agency Review process
- Clinical learning for all cases has been shared in detail with clinical staff and shared through CDOP
- JAR process for all unexpected child deaths in 2020/21 was triggered
- When a child dies: A guide for parents and carers available
- Key workers appointed for all child deaths

Context	Keyworker
Home Office Post Mortem/RTI	TVP Family Liaison Officer
Neonatal < 28 days	RBH Bereavement Midwife
CYP with life limiting illness, already known to service	Children's Community Nurse
Child or sibling < 5 years	Health Visitor
Otherwise	Decided in JAR

Key Achievements:

- Berkshire West and the RBFT are essentially compliant with October 2018 – Child Death Review (CDR) Statutory and Operational Guidance
  - Berkshire West Child Death Review meetings are established
  - Berkshire Oxfordshire Buckinghamshire (BOB) thematic review panels are established
  - SUDEP April 2021
  - BOB thematic CDOP working group safe sleeping established 2021- 22
- Pan Berkshire Suicide Audit 2015 – 2020 for 0-25 year olds led by NHS England completed, presented to the Pan Berkshire Suicide Prevention Steering Group. Thematic findings will contribute to the 2021/22 refresh of the all age Berkshire suicide prevention strategy.
- Berkshire West Child Death Review (CDR), SUDI/SUDIC and Covid-19 - interim arrangements were agreed
- Dr Sarah Hughes Paediatric Consultant in Neurodisability has had 0.5 PA to support Child Death Review (CDR) process since August 2020
- Pan Berkshire key worker audit completed by Dr Hughes findings and recommendations presented to CDOP, demonstrates training and support needed
- Additional capacity in the RBFT Child Safeguarding Team will support the appointment of keyworker for unexpected medical death in child > 5 years
- RBFT Lead Mortality Nurse has familiarised herself with the CDR process by shadowing the Designated Professional and attending meetings to better understand the case management need.
- Training - Saving Young Lives Child Death – Overview and Learning sessions has been provided at all face to face full day level 3 child safeguarding days.
- Deaths of children and young people in Berkshire with LD are notified to LeDeR following a full review at CDOP.

Key Challenges:

- Eighteen JARs the highest number since the Child Death Overview Panel (CDOP) was established in 2008
- Complexity of cases
- Appointment of keyworkers with knowledge and capacity
- Appointment of keyworker for unexpected medical death in child > 5 years
- Capacity within the RBFT to case manage unexpected child deaths
- First Covid lockdown delayed the Coronial process
- Covid lockdown impacted on availability of face to face bereavement support for parents, carers, siblings and families
- Covid lockdown has delayed training of BHFT Rapid Response nursing team to provide a joint home visit
- Medical examiner for < 18 years not yet in place
- JAR process for unexpected neonatal deaths in the neonatal unit and maternity services not being triggered consistently

Key Areas of Work for 2021/22

- Work with partner agencies in Berkshire West ICP to develop a robust strategic approach and plan to adolescent risk reduction and contextual safeguarding, including safeguarding and welfare at Reading Festival
- Work with CDOP colleagues across BOB ICS through a Safe Sleeping task and finish group. The project will include an audit of cases and collaboration with public health colleagues and University of Reading to explore behavioural research
- Work with the Lead Mortality Nurse to develop a business case for child mortality nursing capacity
- Align and streamline RBFT neonatal and paediatric mortality review and Berkshire West Child Death Review processes
- Build the Morbidity and Mortality (M&M) Procedure for Thames Valley and Wessex Paediatric Critical Care Operational Delivery Network (TVWPCCODN) adopted in February 2021 into the RBFT serious incident response to a child death in our care.
- Review the process when there is a neonatal death in the Neonatal Intensive Care or Maternity Services reaching the criteria for a JAR to be reviewed to ensure it is consistently triggered and there is a consistent multiagency response
- Support a Half Day TEAMS multiagency training for Berkshire Health Care Rapid Response nursing team to provide a joint home visit
- Succession planning – from 01/04/2021, Dr Ravi Kumar, Consultant Paediatrian is shadowing and supporting the Designated Professional for Child Death and will take on the responsibility and accountability on the 31/12/21
- Work with Lead Medical Examiner to explore ME model for < 18 years

Ongoing child death review challenges / risks:

- Allocating a key worker with the capability and capacity to provide the standard of support described in the Child Death Review (CDR) Statutory and Operational Guidance to every bereaved family.
- Effective case management of all unexpected child deaths.
- Quality of life issues for children with complex/chronic conditions.
- Supporting frontline professionals following an unexpected child death.
- Knowledge, skills, competence and confidence of multi-agency frontline managers and practitioners who rarely encounter unexpected child death
- Provision of out of hours' joint home visit and immediate family support – unexpected child death.

13. SEXUAL HEALTH

Key achievements – service delivery and safeguarding

- Clinical delivery in the hub at 21a Craven Road continued throughout the Pandemic
- Services changes to adhere to pandemic guidance whilst still maintaining accessibility for vulnerable patient groups
- There are specific outreach clinics for young people across the three Local Authorities of Berkshire West, provided in various settings. Staff deliver holistic care from these venues. These were able to continue to be provided throughout the pandemic for the majority of the time
- Designated outreach posts dealt clinically with 390 vulnerable cases that would not otherwise have accessed mainstream delivery. Service delivery continued throughout the Pandemic with guidelines for modified practice within patient's homes.
- The designated sexual health outreach nurse for young people is the key front line member of staff exposed to, and dealing with, operational issues and the clinical care of young people affected by or at risk of Child Sexual Exploitation and/or Criminal Exploitation (CSE/CCE).
- Safeguarding process – all young people under the age of 18 (and anyone with vulnerabilities identified during history taking) has a full safeguarding assessment carried out at the time of consultation.
- Sexual Health Department contributes to Level 3 Child Protection Training and CSE/CCE training.
- Sexual Health delivers child safeguarding training sessions for at least 1 hour every other month to all staff in clinic.
- A consistent and current flagging system exists between the safeguarding team and sexual health to ensure children and young people subject to child protection plans or Looked after Children are identifiable on both EPR and the sexual health systems to alert clinical staff to vulnerabilities.
- Recruitment of an experienced Outreach Nurse to serve the under 19 age group.

Key achievements – Child Sexual Exploitation/Child Criminal Exploitation (CSE/CCE)

Close working relationship with Head of Children's Safeguarding for Berkshire West Clinical Commissioning Groups (CCG) sharing good practice. The Trust Safeguarding Exploitation proforma has been reviewed and updated to include questions about weapon carrying and also 'sexting'. Staff training now includes guidance on what actions need to be taken if these issues arise.

- Provision of equal input across all three Berkshire West local authorities which involves preparation for and monthly attendance at the CSE/CCE operational group meetings in three unitary authorities.
- Attendance at CSE/CCE workshops, review meetings, audit and challenge meetings
- Attendance at the 3 locality strategic group meetings continues
- Internal CSE/CCE Information Sharing processes continue to guide practice
- Pan-Berkshire Information Sharing and Assessment agreement and Protocol is embedded within Berkshire Child Protection Procedures to which all BWSP statutory partner agencies, including the RBFT are signatories
- CSE/CCE is embedded into the Trust Child Protection Clinical Governance agenda as a standing item.
- Sessions to share good practice between similar clinics in the neighbouring areas have encouraged enhanced ways of working.

Information sharing – change in practice

In addition to children who are considered to be LAC and/or on CP plans we are now able to alert practitioners to those young people (YP) who are also discussed at exploitation committees by using a prefix for their entry into the patient database. This has been devised with guidance from Information Governance and considered to be good practice by Public Health England. We are able to include those YP not already known to the service should

they become known at a later date. This continues for at least 12 months (depending on continuing risk) after the young person's 18th Birthday to ensure any pre-existing or pre-involved services can be considered.

Key areas of work 2021/22

- Ensuring safeguarding protocols continue to be upheld during any ongoing pandemic situation. This will continue to be a priority going forward as the Sexual Health Service faces the ongoing challenge of providing the best quality service whilst adhering to new protocols (ie Social Distancing/Telephone Triage/Smart Triage for Vulnerable patients).
- Continued participation in Pan-Berkshire Exploitation sub group.
- Review of clinic/outreach staff members safeguarding supervision in line with new National Guidance and existing local policies.
- Development of enhanced safeguarding discussion training sessions in newly formed MDT (in addition to all staff receiving up to 6 sessions annually)
- Review of safeguarding supervision against new British Association of Sexual Health and HIV guidance, 2021

Ongoing sexual health challenges / risks:

- Management of all safeguarding circumstances continues to be a challenge in relation to capacity within sexual health services with the ever changing safeguarding agenda.
- Recruitment in progress to replace 2 members of the Outreach Team
- Capacity to attend meetings if they are extended to include more young people will become more challenging.
- Time out of service delivery, for the Specialist Youth Nurse to attends/contribute to extended meetings for each local authority each month.
- Time it takes for RBFT (both sexual health and main Trust EPR) patient records to be checked so proportional information can be shared, where appropriate, in line with the information sharing policies.
- Ensuring appropriate input continues into the Local Authority pathways as they find different ways of working to consider Contextual Safeguarding.

14. SAFEGUARDING ADULTS

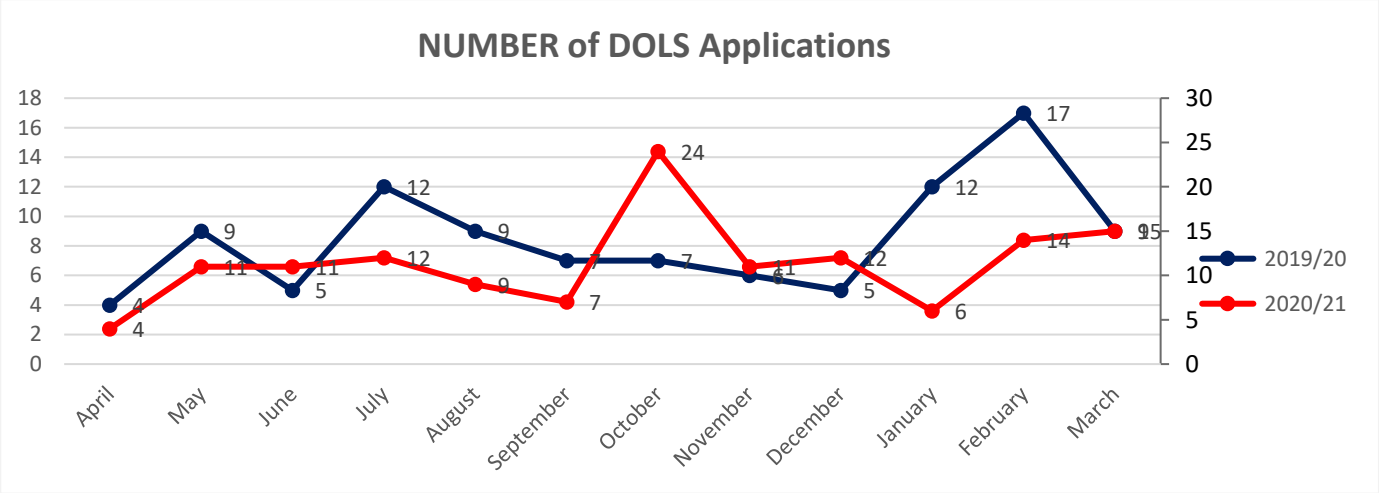
Key achievements

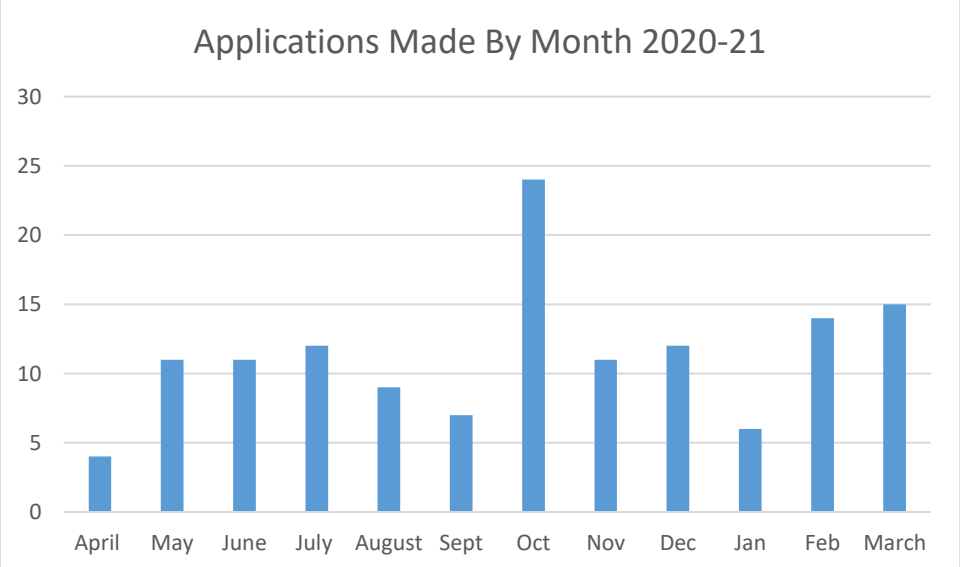
- During Covid19 the Safeguarding Team remained on the RBH site and provided face to face assessments and support for patients and staff in both hot and cold Covid wards and departments
- All safeguarding allegations raised against staff by patients and others have been investigated.
- The Safeguarding Team were part of the Family Liaison Service C19 that had good feedback from frontline staff and the families we worked with. That service was stepped down in August as it is no longer needed. It was recognised as filling a gap and very real need while visiting was suspended with some exceptions.
- The RBFT contribution to the Covid 19 care homes work in Berkshire West included drawing up the visit 'check list' and 19 visits in 3 weeks made by the Lead Nurse Adult Safeguarding, the Practice Development Team and Associate Chief Nurse for Workforce and Education
- Safeguarding Adults Clinical Governance continued throughout 2020/21
- The NCG safeguarding team medical clinical lead and matron have worked with the NCG Board to embed safeguarding governance and accountability
- UCG and PCG safeguarding matrons leads are members of the Safeguarding Adults Clinical Governance group and have provided valuable connections into their care groups

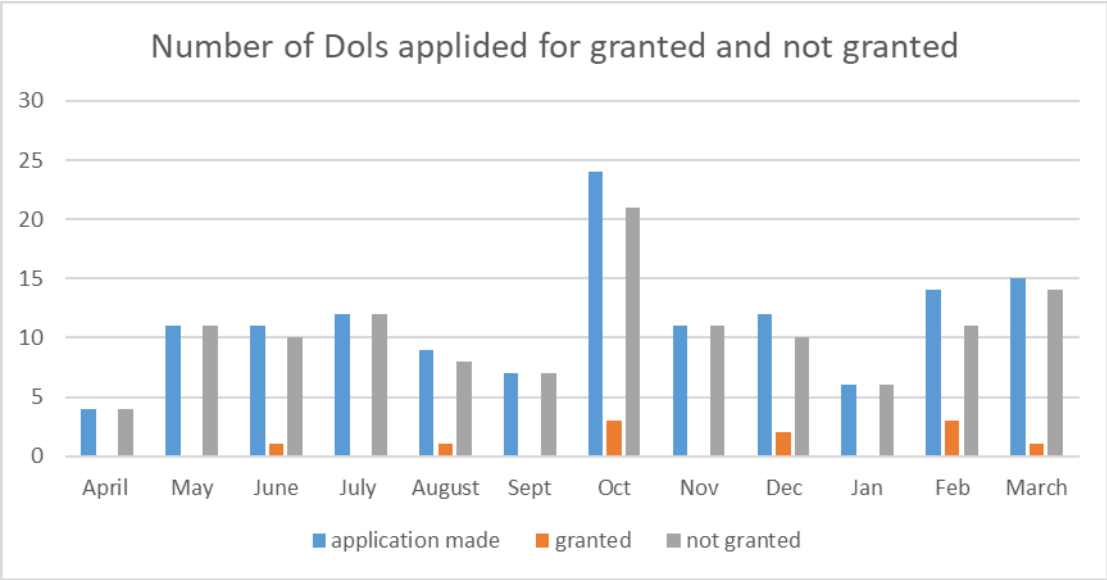
- Safeguarding concerns continue to be raised via the Datix incident reporting system 2020/21 saw a 20% rise in concerns reported
- Learning from Safeguarding Adult Reviews (SAR's) continues to be included in Safeguarding training
- The Lead Nurse Adult Safeguarding continues to be part of the SAR panel and other SAB subgroups

14.1. Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

- Staff knowledge of the Mental Capacity Act has improved. While this is a good assessment of the status of the Trust, work is still required to embed the knowledge, skills and consistency of staff in application of the MCA
- Face to face Training for induction and core mandatory training was discontinued due to Covid restrictions
- Enhanced mental capacity training was recommenced in September2020 via MS teams sessions held on alternate months. Mental Capacity training also forms part of the managing 1:1 day
- A ward level point prevalence audit was undertaken in December2020 The finding were similar to previous audits and highlighted limited documentation of MC assessments and best interest discussions and meeting. However there was good documentation of clinical discussions with families
- There was an increase in the number of DoLS applications made in 2020/21 where 136 application were made compared to 102 applications in 2019/20 an increase of 33%
- Of the 136 DoLS applications made only 8(6%) were granted compared to 2019/20 where 11(11%) of the 102 applications were granted. The majority of patients were discharged or unfortunately died prior to the DoLS assessments being undertaken and completed.





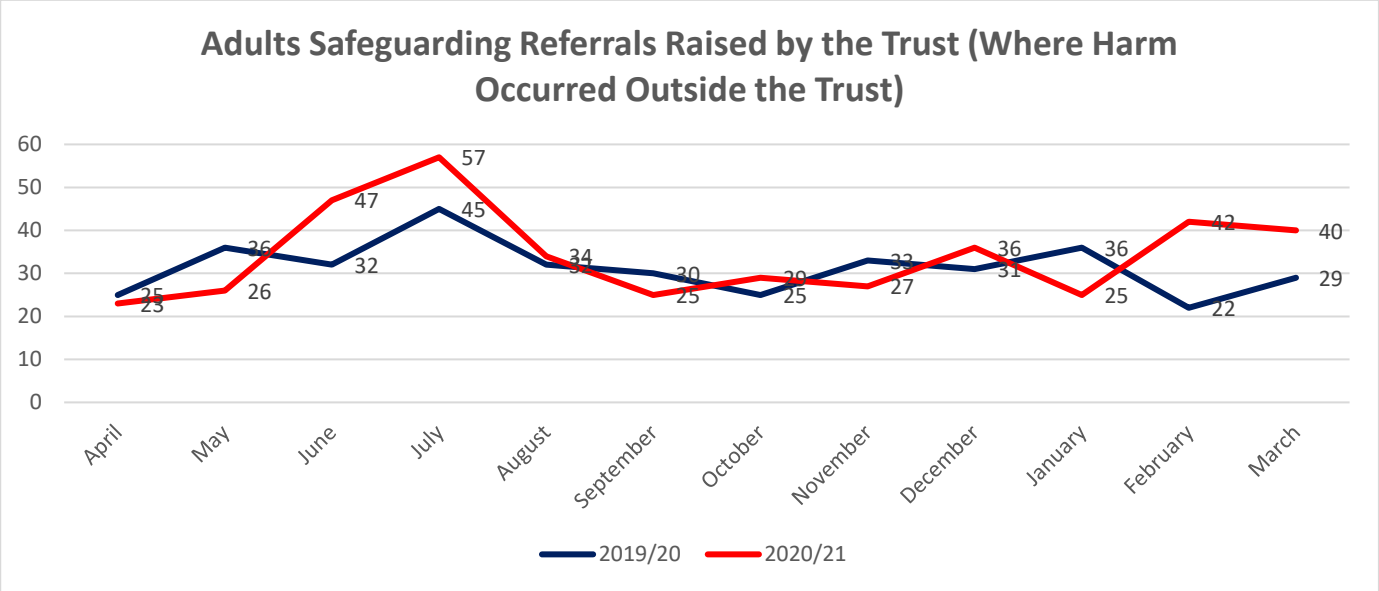


14.2 Adult safeguarding concerns

- All concerns raised by our staff about potential harm or abuse outside of the Trust are reviewed by the local authority and if necessary investigated through the safeguarding process
- During 2020/21 411 adult safeguarding concerns were raised to the local authorities compared to 341 in 2019/20 a 20% increase
- For externally raised safeguarding concerns about care a fact finding exercise is carried out by the Lead Nurse Adult Safeguarding. This information is given to the local authority for them to decide on the type of investigation and outcome of the concern. In most cases the safeguarding concerns raised against the Trust continue to be around pressure damage and discharge processes. In the majority of cases there continues to be a lack of information provided about pressure damage as part of the discharge process
- Safeguarding concerns reported within or raised to the Trust related to staff members are investigated under our Managing Safeguarding Concerns and Allegations Policy.

Safeguarding Concerns Raised During 2020/2021

Month	Concerns raised by the Trust where harm occurred outside the Trust.	Concerns raised against RBFT	Concerns reported by RBFT where harm alleged to have occurred within RBFT
April	23	2	1
May	26	0	0
June	47	3	0
July	57	6	3
August	34	3	0
September	25	1	1
October	29	1	0
November	27	6	0
December	36	6	2
January	25	5	0
February	42	1	0
March	40	3	1



14.3. Prevent (anti-terrorism)

One Prevent concerns was discussed with outside agencies in 2020/21. Two members of the Safeguarding team regularly attend West Berkshire Prevent steering group.

14.4. Domestic Abuse

Work is on-going to embed principals of good practice throughout the Trust including raising the awareness, routine enquiry and encouraging the use Domestic Abuse Stalking and Harassment (DASH) forms. The Safeguarding Practitioner regularly attends the three Local Authority Multi- Agency Risk Assessment Conferences (MARAC's). Victims identified as being High Risk by MARAC representatives, continue to be flagged on EPR for 12 months following the risk discussion. The Domestic Abuse Working Group will be relaunched in 2021

Key areas of work for 2021/22

- Support the multi-disciplinary safeguarding champions and care group safeguarding adult medical leads and matrons to embed safeguarding across the Trust
- Relaunch the domestic abuse working group
- Promote the importance of clear documentation of mental capacity; this can be by either use of paper or electronic documentation of Mental Capacity assessments
- Work with Capsticks the Trust's legal firm for them to design and deliver Advanced Mental Capacity Act and Best Interest training for senior clinicians to be part of our new Level 3 adult safeguarding training programme
- Launch Level 3 adult safeguarding training, work with the team that manage 'Learning Matters' the electronic platform used to record and report safeguarding training to accurately recording this training
- Work with other members of the safeguarding team to review existing training methodologies to include virtual class room and digital opportunities developed during Covid, including expanding a 'train the trainer' approach and reflective peer review sessions
- Support the Safeguarding Adult Board work on safeguarding and pressure ulcer prevention and financial abuse
- Prepare for the implementation of Mental Capacity (Amendment) Act May 2019, new Liberty Protection Safeguards, originally planned by the government from April 2021 delayed until April 2022.

On-going safeguarding adults' challenges / risks:

- Year on year increase in activity for vulnerable groups with multiple co-morbidities and complex psycho-social problems. This inevitably impacts on the capacity of the Safeguarding and clinical teams to respond.
- Supporting patients and the staff caring for them where there are complex health, safeguarding and a psycho-social needs leading to delayed discharge from hospital due to system intricacies
- Supporting patients and the staff caring for them where there is homelessness or other external service or resource issues beyond our control
- Vulnerable patients who don't reach thresholds for statutory or voluntary services and the differences between local authorities.
- Increasing and maintaining workforce knowledge of the Mental Capacity Act, DoLS, Best Interest Decisions and application in practice.
- Consistency of documentation on EPR especially in relation to Mental Capacity Assessments
- Increasing and maintaining workforce knowledge of domestic abuse and application in practice
- Capacity to implement the new legislation and statutory guidance specifically the Mental Capacity (Amendment) Act May 2019, new Liberty Protection Safeguards and the Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health and Social Care Staff 2018

15. MENTAL HEALTH SERVICE PROVISIONS

In addition to the participating in the Berkshire West ICP Mental Health and Learning Disability Programme Board the Trust has worked in partnership with Future in Mind - a group responsible for developing and monitoring the Local Transformation Plan for Children and Young People's Mental Health and Wellbeing and the Pan Berkshire Suicide Prevention Group. Caring for people who have mental health problems is probably more important than ever as health and social care agencies tackle the long term consequences of Covid-19. Following lengthy consultation with service users, their families and key agencies, the Berkshire West Mental Health and Learning Disability Programme Board drew up a 14 point plan of action to improve mental health crisis pathways. In line with the Government's Long Term Plan for the NHS, the Board is committed to a rapid expansion of its mental health services, improving and widening access to care for children and adults. Berkshire West population is 570 000 with average of 20.9% BAME composition. About 70 000 people have a diagnosis of anxiety and/or low/moderate depression across Berkshire West. Only 12% are from a BAME background, possibly underrepresented compared to white communities. The average age of people with a diagnosis is 48 which implies anxiety more prevalent amongst the younger population and 63% were females. This project will support in improving on our data reporting - fewer BAME males accessing mainstream mental health services, understanding BAME experiences of accessing early help and improving access to culturally appropriate psychological support (IAPT). People from BAME group with anxiety and or low, moderate depression make up 51% living in Reading, 25% in West Berkshire and 24% in Wokingham (Population Health Management dataset October 2020).

Aims of the mental health crisis plan:

- Improve access to mental health services and make them readily available in a timely manner
- Expand the mental health liaison service through the Royal Berkshire Hospital's Emergency Department
- Improve 24/7 mental health crisis provision
- Provide alternative crisis provision like sanctuaries/crisis café
- Establish a new Ambulance Mental Health response pathway with trained mental health staff

Key achievements of the multi-agency partnership during 2020/21:

- A single point of access for Mental Health Crisis that is consistent and available 24/7 for all ages
  - Single point of access available via NHS 111

  - A new Mental Health Crisis Line since April 2020 for all ages; children and young people, adults and older people with access 24/7, 365 days a year. Supports people with Learning Disabilities
- Psychological Medicine Services (PMS- Mental Health Liaison Team at RBH) Core24 compliant
- Successfully recruited two Drug and Alcohol specialist practitioners collocated with PMS on the RBH site to support people in need, frontline clinical teams and link with the community substance abuse services
- Review of the secure ambulance use criteria and contract
- Launch of Kooth young people online support service a free, safe and confidential online space to share experiences and gain support from the managed online community and qualified professionals. Young people access Kooth can do so without the waiting lists or thresholds often associated with traditional services. They can join online peer support communities, access self-help materials or engage in drop-in or booked one-to-one online chat sessions with experienced counsellors.
- Mental Health Support Teams (MHST) to support children and young people with emerging, mild or moderate mental health difficulties launched in Reading and Wokingham.
- Funding identified for a Band 7 CAMHS practioner within the RBH
- In December 2020 The Berkshire West CCG Joint Commissioning Team was awarded £20,000 by NHS England for Mental Health Winter Pressures to increase capacity within our local Voluntary and Community Sector Advocacy Organisations (VCS) in improving engagement with vulnerable communities. The Black, Asian and Minority Ethnics groups, Refugees and Traveller communities (BAMER*) was chosen to meet this criteria of vulnerable communities. The VCS organisations provided support to people from BAMER communities in navigating and accessing mental health support to prevent mental health crisis. This project operated from beginning of January to the end of March 2021.
- Participated in a Pan- Berkshire Suicide Audit 0-25 years organised by NHSE Specialist Advisor, CYP Mental Health, South East and a Pan-Berkshire Suicide Audit in females. The findings will contribute to a 'life course' renewed suicide prevention strategy and plan in Berkshire in 2021/22

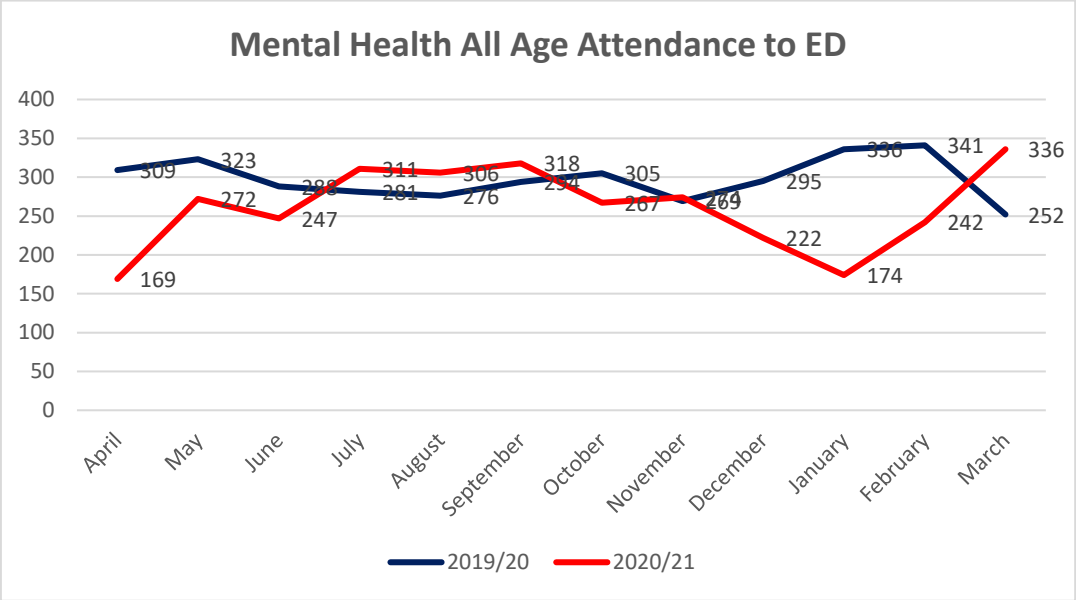
Key Areas of multi-agency partnership working looking forward to 2021/22 and beyond

- The RBFT will participate in a working group and sub groups of the Pan Berkshire Suicide Prevention Group commissioned to agree priorities for the life span refresh of the Pan Berkshire Suicide Prevention Strategy
- Procurement of an alternative to Crisis provision for the first Crisis Café location in Reading accessible to all Berkshire West residents
- Improving Primary and Community Mental Health services by embedding services in Primary Care and by working collaboratively with Voluntary sector organisations.
- Building an integrated mental health crisis offer for children and young people 0-18 years (17 and 364 days):
  - Single point of access including through 111 to crisis support, advice and triage
  - Crisis assessment within the emergency department and in community settings
  - Crisis assessment and brief response within the emergency department and in community settings, with CYP offered brief interventions
  - Intensive Home Treatment service aimed at CYP who might otherwise require inpatient care, or intensive support that exceeds the normal capability of a generic children and young people's mental health community team
  - Develop a new Tier 4 out of hospital service using evidence from intensive community models that are demonstrating success elsewhere in the country
  - Willow House Tier 4 inpatient provision closed on April 30th 2021 with transition to the new service model commencing from March 2021.
  - The new local clinical service will meet the needs of young people who would have been admitted to a general adolescent unit or specialist unit such as an eating disorder unit they will at remain at home
  - The service will have capacity to support 16 young people at any one point in time, more than the 9 supported at Willow House.

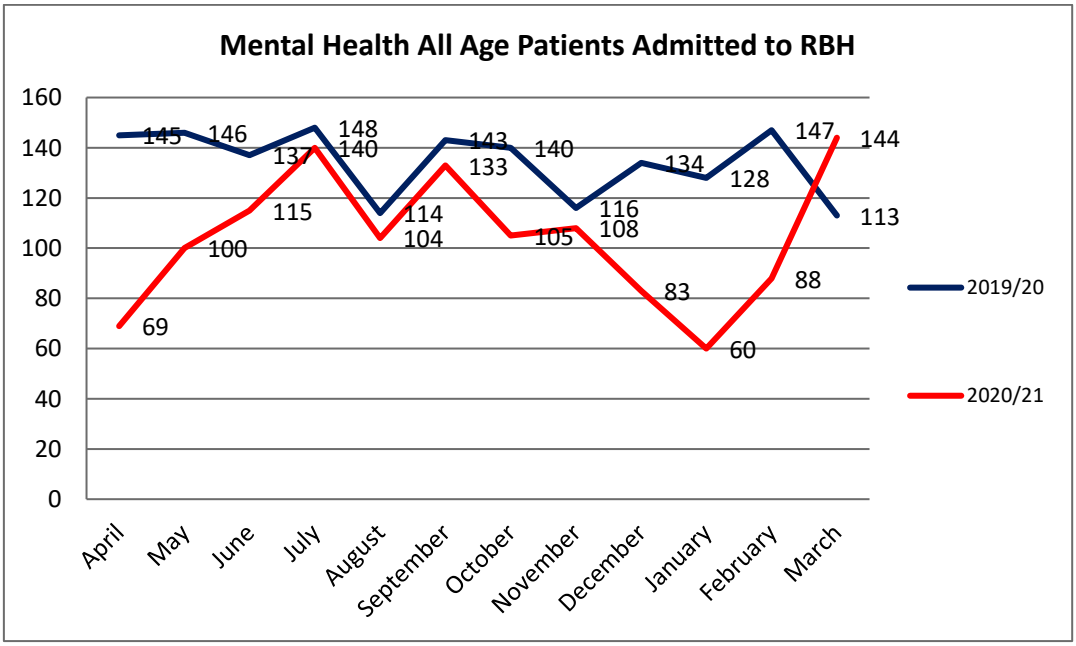
- Young people who need an in-patient response will mostly go to units in the region e.g. Huntercombe in Maidenhead or Highfield in Oxford.
- This will continue to be organised through our Thames Valley Provider Collaborative, with the Berkshire Service remaining as the Access Assessors.

15.1 Activity

Activity data provided by the Trust's Emergency Department (ED) shows that on average, 262 people per month primary mental health presentation in 2020/21. However, this is not representative of monthly figures for 2020/21 due to the COVID-19 impacts. 2020/21 has seen the lowest attendance in recent years in April 2020 and January 2021 and the highest attendance in March 2021 coinciding with national lockdowns and subsequent easing of restrictions.



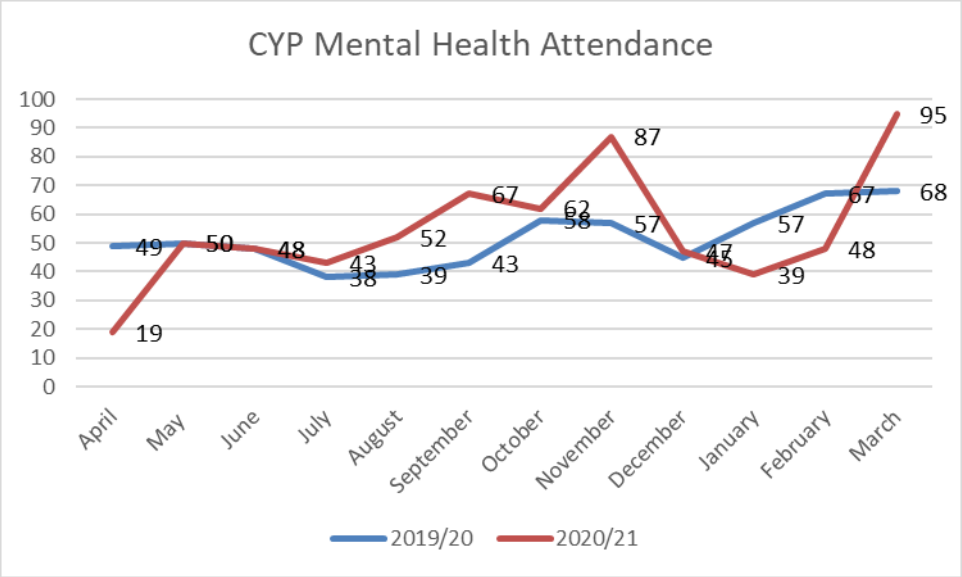
Annual attendance: 2017/18 – 3111
2018/19 – 3728
2019/20 – 3569
2020/21 – 3138



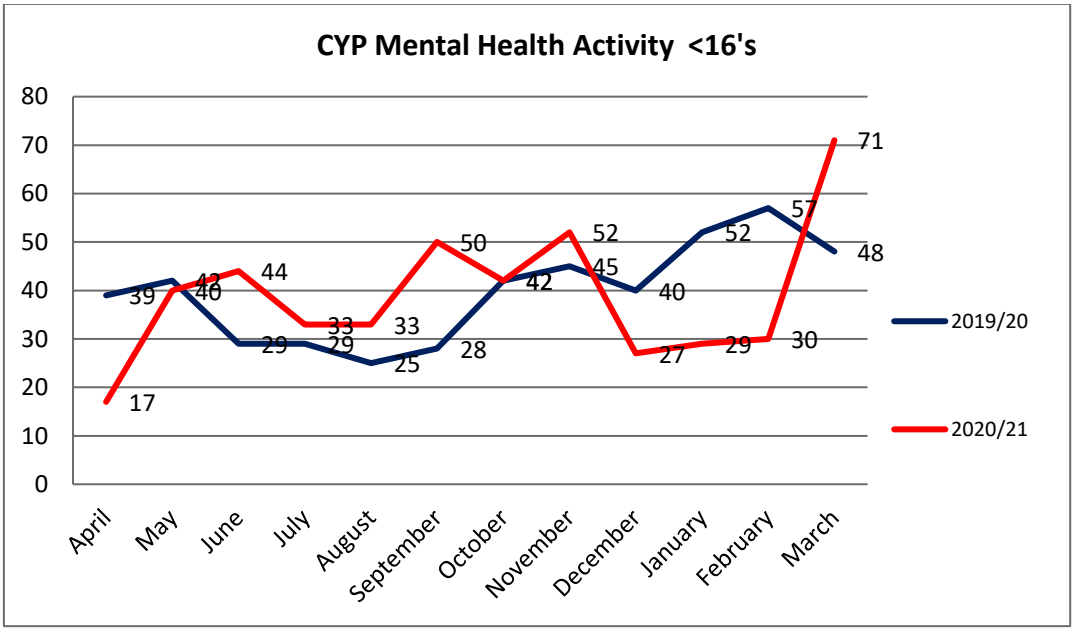
Annual admission rates to attendance: 2017/18 – 1710 55%
2018/19 – 1841 49%
2019/20 – 1611 44%
2020/21 – 1249 40%

The percentage of admission of those attending has reduced however the length of stay of the most complex patients has increased.

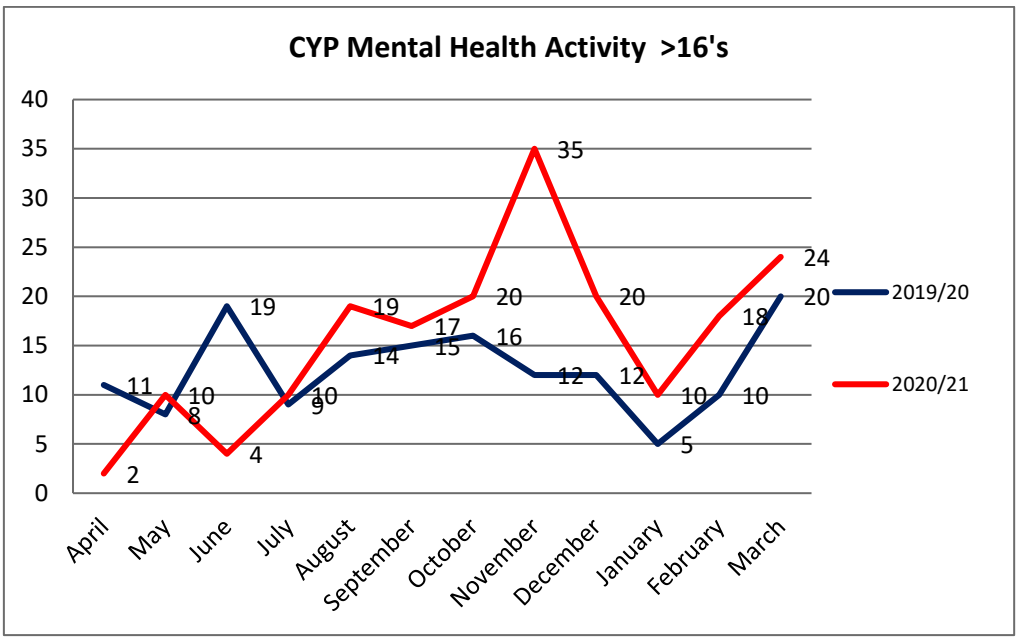
Attendance of Children and Young People through ED has seen a year on year increase over the past 4 years. The age profile of these attendees had changed with the overall increase due to a higher number of under 16 year olds presenting with mental health issues. However from 2019/20 to 2020/21 there was a 5% increase in attendance for all children and young people, 2% decrease for under 16's and a 25% increase for 16/17 year olds.



Annual attendance under 18's: 2017/18 – 508
2018/19 – 566
2019/20 – 626
2020/21 – 657



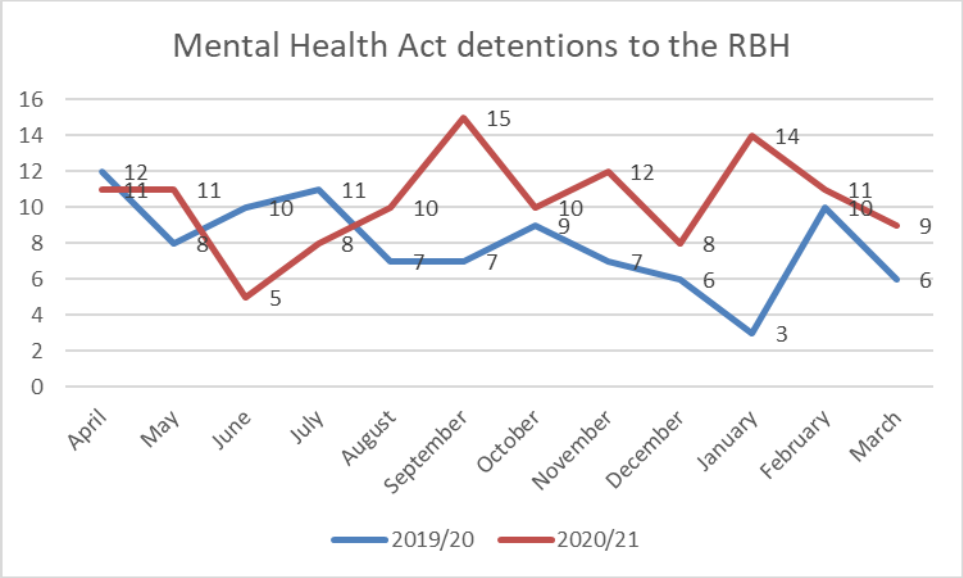
Annual attendance under 16's: 2017/18 – 316
2018/19 – 420
2019/20 – 476
2020/21 – 468

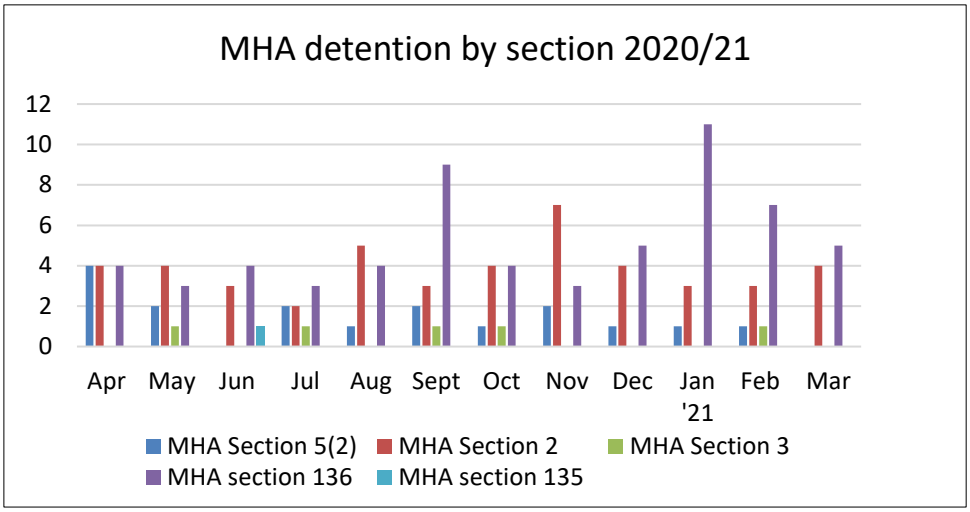


Annual Attendance of Over 16' s 2017/18 - 192
2018/19 – 146
2019/20 – 151
2020/21 – 189

15.2. Mental Health Act 1983 (as amended in 2007) Detentions to RBH (including S136)

- Detentions under the Act to the Royal Berkshire Hospital have been section 2, section 3, section 5(2) and section 136 (police powers).
- There were 52 Section 2 and 3 detentions to the RBH in 2020/21 compared to 44 in 2019/20.
- An annual increase of 18%.
- Use of Section 5(2) was 17 in 2020/21 compared to 15 in 2019/20.
- An annual increase of 13%.
- There were a total of 62 presentations of patients detained on Section 136 (including 1 S135) at the RBH Emergency Department (ED) in 2020/21, including 9 children/young people compared to 37 in 2019/20
- This is an annual increase of 68% from 2019/20, an increase of 226% over the past 4 years from 19 in 2017/18.





Please refer to Annual Mental Health Act 2020 Report for more detailed information.

NB: while the majority of these patients were detained to the wards in the Royal Berkshire Hospital due to requiring treatment for their mental and physical disorders, there were a number of patients who had no physical disorder and were awaiting a mental health placement.

Summary

- Attendance of Children and Young People has increased due to a higher number of over 16 year olds presenting with mental health issues
- The complexity of those attending continues to increase.
- Presentation of eating disorder diagnosis and increasingly atypical eating disorders or "disordered eating" associated with conduct disorders has continued to rise.
- Increase in behavioural issues, self-harming and reports of suicidality amongst young people presenting with Autistic Spectrum disorder or awaiting ASD assessments.
- Lack of availability of Specialist Eating Disorder inpatient beds and CAMHS inpatient beds nationally
- Covid - 19 pandemic has affected attendance to ED of adults significantly with the lowest and the highest attendance during lockdown and easing of restrictions
- 2020/21 has seen the highest annual attendance of young people to the RBH with mental health presentations.

Key achievements

- Second Mental Health Tier 1 Tribunal held successfully in November 2020 and conducted virtually.
- Pilot training sessions from Maybo for personal safety and conflict management training completed across care groups.
- ED Frequent Attenders initiative re-established.
- Suicide and Self-Harm Working Group has achieved its targets for reviewing and completing the Self-Harm and Suicide Reduction audit in September 2020
- BHFT has introduced new role of Practice Development Practitioner to work across RBH and WPH – good links made already
- Good liaison between Clinical Site team and MH Lead Nurse to support patient flow between Prospect Park and Royal Berkshire Hospitals and around Mental Health Act administration.
- Review of MHA Service Level Agreement between RBFT and BHFT completed for 2021
- Managing Illicit substances on Trust Property and Misuse of substances in an Acute setting Policy approved.
- We worked in partnership with BHFT to review and redesign the CAMHS Rapid Response Service mental health pathways for CYP and PMS/OPMHLT pathways within RBH for adults during Covid19
- Transport provision for mental health patients between hospitals for Berkshire West patients has been developed and implemented and will be continued to be reviewed for effectiveness and efficiency.

- The RBFT Occupational Health Manager worked with BHFT to develop an offer to support the emotional and mental health of our staff, with three elements: Intranet content, including training for managers about implement basic support structures. Access to a confidential listening and support line manned by psychological therapists. Wellbeing Support Hubs for teams facilitated by psychological therapists.
- The TOR for the Joint RBFT & BHFT Mental Health & Learning Disability Governance & Partnership Meeting were reviewed and agreed as a forum for joint discussions, partnership working and shared learning between the Royal Berkshire NHS Foundation Trust (RBFT) and the Berkshire Healthcare NHS Foundation Trust (BHFT) on all issues pertaining to the governance of mental health and learning disability patients. The group identifies initiatives to improve pathways and the quality of care provision and experience for patients with mental health disorders, learning disability and ASD who also have physical health disorders and require the services of both the RBFT and BHFT.

15.3. Compliance with the Mental Health Act 1983 and Mental Health Act Code of Practice, 2015

The Annual Mental Health Act Report 2019/20 is discussed, consulted on and approved through the Joint RBFT/BHFT Mental Health Committee, the Strategic Safeguarding Committee and the QALC, the Executive Management Team and the Quality Committee. This report provides assurance about key issues, risks and themes, Trust compliance with the Mental Health Act and Code of Practice.

Please refer to Annual Mental Health Act 2020/21 Report for more detailed information.

15.4. Liaison Psychiatry in the Royal Berkshire Hospital – Psychological Medicine Service (PMS) and CAMHS Rapid Response Service

There continues to be a high level of support for patients presenting with mental health needs. The mental health liaison teams work collaboratively with RBFT staff to ensure all ages of service users with mental health needs are adequately assessed, treated and signposted as necessary. CAMHS, paediatric and ED staff have developed a regular operational meetings in order to achieve a collaborative way of working.

CAMHS Rapid Response Service has extended its operational hours. Operates from 8am-10pm Mon-Fri; 10am-6pm Sat, Sun and Bank Holidays with out of hour's support for crisis management being provided by an on-call CAMHS Consultant and the nursing team at Willow House. Willow House is a 24/7 9 bedded tier 4 CAMHS in Berkshire.

Willow House is due to change its provision in 2021/22 to increase their caseload and support young people with an extended and specialist day and community service.

15.5 Challenging Behaviour Self-Harm and Suicide Prevention

Zero Tolerance - Safeguarding, challenging behaviour, self-harm & suicide prevention steering group became established to identify and action risk reviews and promote safer management strategies. The group is working towards a zero tolerance of violence and aggression towards our staff and of self-harm and suicide attempts within the Trust.

- Quarterly meetings are well attended, there is good engagement from care groups including People & Change Partners.
- October 2020 saw the launch of Trust-wide zero tolerance to challenging behaviour, violence and aggression campaign, and the 'I'm here to help, not to be hurt' posters
- Working groups have been set up: Improving reporting on Datix; Training; Violent Patient Marker Policy implementation – ED pilot; LD/ASD reasonable adjustments
- Datix reporting in ED has been improved through simplifying the form and developing a response to reporting of 'wilful' violence and aggression by capacitous patients.
- ED Zero tolerance pilot was launch in December, this involves warning cards, yellow, amber and red cards can be shown to visitors and patients who are wilfully displaying unacceptable behaviour.

- Prompts on the back of each card assist staff in communicating the significance and potential consequences of the person's actions clearly and calmly.
- The pilot excludes patients who lack mental capacity including those with severe mental illness, dementia and learning disability and under 18 years.
- Since the pilot started we have revised and agreed the template for amber and red letters, established a process for amber and red letters to be sent out, flags applied to EPR and letters to be sent to GPs
- Working with our Patient Information Manager the ED team have developed leaflets to be given to patients who are shown yellow, red and amber cards and sent letters.
- Conflict management training and training in physical restraint and holding are an important part of the pilot details can be found in the training section of this report
- Self-Harm and suicide reduction (incl. ligature) environmental audit 2020 final figures NCG 100%; PCG 100%; UCG 66% (all red RAG areas audited); overall 85%
- Lead Nurse for MH monitors and responds to all self-harm/suicide related incidents and provides monthly reports for thematic learning/action and supports teams to complete risk assessments for individual patients through training and case support

Key concerns

- Data for patients who are detained under the MHA "transfers in" and S136 remains dependent on staff reporting and is inconsistent.
- Provision of enhanced 1:1 support including RMN cover where required quality and quantity.
- Consistency of knowledge and skill concerning enhanced 1:1 observation for patients with acute behavioural disturbance including psychiatric observations.
- Delays in discharge of children, young people and adults awaiting specialist mental health beds, including eating disorders.
- The increase in violence and aggression towards our staff and impact and management of challenging behaviour particularly in the ED, AMU and SSU, Paediatric Wards, Elderly Care Wards, Acute Medical Wards, the Neuro-rehabilitation Ward, Trauma and Orthopaedic Wards and Maternity Services.
- Consistency of staff knowledge, understanding and application of MHA in practice, including self-harm and suicide prevention and ability to always recognise and act on risk.
- Challenges presented by the physical environment in an acute health setting.

Key areas of work for 2021/22

- Incorporate revised Responsible Clinician guidance generally and specifically for CAMHS into revised MHA policy
- Review of MHA policy
- Re-establish work between BHFT and RBFT on communication and transfer pathway for patients being transferred between hospitals.
- Work with RBFT Local Security Management Specialist (LSMS) to review guidance on searching high risk patients.
- Recruitment and induction of Specialist CAMHS Practitioner into the Safeguarding team at RBH
- Oversee the annual self-harm and ligature audit
- The Lead Nurse for Mental Health will relaunch the Self-Harm and Suicide Working Group and review the membership

Ongoing mental health service provisions challenges / risks:

- The number of mental health patients of all ages presenting to ED and being admitted.
- Increase in number of children and young with eating disorders being admitted for re-feeding and discharge delayed due to lack of specialist in patient services or their safeguarding or social needs
- Increase in complexity, homelessness, social isolation.
- Gaps in community services for patients who are in crisis, leading to individuals attending ED.
- Delayed Transfers of Care for Prospect Park Hospital and Royal Berkshire Hospital due to lack of specialist beds nationally.
- The number of patients detained to Royal Berkshire Hospital under the Mental Health Act.
- Capacity of the nursing teams and security service to consistently provide a safe environment for high risk patients – enhanced 1:1 care.
- Suitability of acute health care settings when managing patients who are a risk to themselves or others.
- Social care supporting safeguarding risk assessments – in and out of hours, the response is variable
- Challenging behaviour, violence and aggression

16. LEARNING AND COMPLEX DISABILITIES – ADULTS

Key achievements

- Learning Disability Liaison Nurse (LDLN) team increased to 1.4 WTE from 01/04/21
- The Learning Disability Liaison Nurses (LDLNs) remained on the RBH site and provided face to face assessments and support for patients, families and staff in both hot and cold Covid wards and departments.
- 296 in-patient referrals in 2020/21 to LDLN team compared to 264 in 2019/20 a 12% increase
- Additionally there were 230 out-patient referrals
- Referrals to the LDLN team come from health care staff within the Trust, family carers and outside agencies.
- There was a 34% increase in referrals to the LDLN team in the first 3 months of 2021 compared with 2020
- There was a picture of increased LD patient activity, case complexity and intensity
- During the peak of the pandemic the LDLN team were particularly busy supporting an increase in intensity in LD patients admitted to acute medical wards, critical care areas and needing palliative care
- The focus changed to supporting patients with complex needs, families and clinical teams as elective activity resumed.
- The LDLNs maintained a log of the most complex and vulnerable patients whose elective procedures were delay and worked to coordinate access once services resumed
- Planned Care Group professionals and the LDLN team participated in BWCCG Covid swabbing and vaccine group led by BHFT LD Lead.
- Swabbing for elective patients was managed on the RBH site through the drive through ‘tent’, with planning and preparation most LD/ASD patients were able to access this.
- Where necessary swabbing for LD/ASD patients was risk assessed on a case by case basis and carried out in the home setting
- Familiar carer, supporter, personal assistants allowed during Covid and not counted as additional visitors.
- The support for carers was reviewed and we offered swabbing to those who needed carers on site to ensure safety in the elective areas. Easy read ‘Coming into hospital with Coronavirus’ leaflet published on RBFT website in April 2020
- The LDLNs aim to ensure that patients with a learning disability and their carers are effectively prepared before planned surgery and other interventions so that patients aren’t cancelled. The pre-operative teams, the CATs and the LDLNs have worked in partnership to make sure that patients and carers are ready and reassured prior to admission.

- During 2020/2021 there have been several patients who have found even basic medical interventions extremely difficult, have been diagnosed with malignant disease and subsequently supported through treatment. The LDLNs provide support and confidence to carers and other RBFT health professionals when meeting the needs of the patient can be challenging.
- The LDLNs are part of the multi-disciplinary team caring for several people who have a learning disability or autism in the community and who require health input but may not meet the criteria for the community learning disability teams. This group of people change as health and social care needs for individuals stabilise or worsen.
- The LDLNs attend the weekly multi-disciplinary case meetings of the Reading Community Learning Disability Health Team to discuss individuals and develop joint plans for those who need to access care at RBFT. During the Covid pandemic these have been on-line Teams meetings
- The LDLNs attend the West Berkshire Learning Disability Partnership Board meetings when there are issues related to health and RBFT on the agenda and health sub- group meetings of that partnership board. All meetings have been virtual since the start of the Covid pandemic. The focus of the health sub group in West Berkshire LD Partnership Board is the up take up of annual health checks and health screening.
- There has been some notable team working between BHFT and RBFT health care professionals to ensure that patients with a learning disability are receiving equitable care and treatment. The LDLNs are key in supporting health care staff within the Trust to ensure that this happens.
- Attendance at Dingley transition clinics where the LDLNs have the opportunity to meet young people who reside in Berkshire West and are moving from RBFT Children's services to Adult services, and their families. Phone contact is made after clinics when there has been no face to face meeting with the LDLNs.
- Attendance at Reading SEND meetings.
- Contacts have been maintained with parents in Reading Family Forum. The forum raised concerns around DNACPR which had been raised in the national media and caused concern to families. The LDLNs were able to reassure parents concerning practice within RBFT around DNACPR, ReSPECT and how best interest decisions are made in practice when adults and young people present to the hospital and are very ill.
- The nurses have received very positive feedback regarding their input from colleagues within the RBFT and other agencies.

The value of the LDLN role as a central point of communication within the Trust for patients with a learning disability cannot be overstated.

16.1. Deaths of Patients with a Learning Disability

- 20 adults identified as having a learning disability died in the Royal Berkshire Hospital April 2020 – March 2021 compared to 14 April 2019 – 2020
- 7 of those deaths were associated with Covid-19, 5 in March/April 2020 during the first pandemic wave and 2 in January 2021 during the second pandemic wave
- A review of LD Covid deaths in January 2021 showed that since February 2020 we had 6 deaths related to covid, 4 of those had completed SJRs, all graded as a 0 with no learning points identified but evidence of timely intervention and good/excellent care
- There was a high percentage of LD death in first 3 months of 2021 (50% of usual annual expected in January)
- Patients who die whilst an inpatient at RBFT are subject to a triage mortality review within the organisation
- Where concerns are identified about practice the case is considered against Serious Incident Requiring Investigation (SIRI) criteria, two cases met the criteria in 2020/21
- The purpose of the reviews is to gather information about the individual who has died and report to the programme to identify learning and positive practice
- Themes which are emerging that should ultimately contribute towards the aim of reducing premature death in people with a learning disability include recognition of the deteriorating patient, especially with reference to sepsis, mental capacity assessments being completed in a timely manner, easy read and accessible information being available to LD patients, and the importance and benefit of family and familiar carers
- The quality of care and compassion provided by RBFT services in relation the people with LD and end of life care identified in Berkshire West LeDeR and CDOP multiagency death reviews has continued to be very positive.

- The LDLN and RBFT Palliative care team have developed strong and consistent working links in 2020/21. A LDLN attends all palliative care MDT's for patients with a learning disability. This has helped to facilitate more people with learning disabilities going home to die

16.2. LeDeR Programme

- Learning from Lives and Deaths- People with a learning disability (LeDer).
- All deaths of people with learning disabilities are reviewed under this process. It aims to improve health and social care, reduce health inequalities and prevent premature death of people with learning disabilities.
- Berkshire West CCG had 52 LeDeR cases outstanding on 31st of June 2020 this accounts for patients with learning disabilities who had died across all settings in community and acute.
- RBFT contribute information about the person's care and treatment in the 6 months leading up to a person's death.
- Regular meetings with the Learning Disability colleagues in BHFT and RBFT were arranged to assist a smooth flow of information needed to complete these reviews.
- From October 2020 to December 2020 0.2 WTE LDLN from RBFT was seconded to BWCCG to support the RBFT information gathering for LeDeR reviews.
- All the outstanding reviews were completed by 31st of December, 2020- the LDLN contributed to 44 of these cases.
- The LDLN service allocate up to a day a week to ensure that there is no delay from RBFT contributing to these reviews.

Key findings and learning from the LeDeR Annual Report for Berkshire West CCG 2020/21

- Support workers and families being listened to by health professionals and their views being a key part of any decision making
- Communications between hospital staff and support workers being formalised to ensure they are updated and able to prepare for supporting the individual when they return to their home
- Supporting care providers, families and support workers to stay if support is felt to be beneficial to reduce anxiety, maintaining continuity and promote greater understanding of the individual's needs.
- Good practice was seen in all the cases reviewed and these need to become more consistently seen. They included:
    - Appropriate specialist consultations and expertise were identified in a number of cases, ensuring care and treatment was comprehensive, enabled adjustments to be made to care and best interest decisions to be made by multidisciplinary teams
    - Examples of good proactive holistic care in which social and spiritual needs were recognised and supported
    - Resources and toolkits appeared to assist in promoting continuity of care, such as the epilepsy assessment tool and a care planning template
    - Several examples were identified of GPs working with individuals to ensure they got their health care, visiting them in alternative locations and working with support workers to reduce anxiety and stress related to physical interventions such as examinations and blood tests.

Key areas identified as requiring further improvement in 2021/22 are:

- Annual Health Checks (AHCs) and Health Action Plans (HAPs) / Education and Health Care Plans (EHCPs) need to be more closely aligned and linked

- Transition from child to adult services needs to start with earlier discussions across teams and service, including primary care. This needs to include hearing the voice of the individual, their views and choices more consistently

- Anticipatory care plans, and preparing for lifestyle changes needs to be more proactively supported cross the system, including end of life choices, best interest decisions, advocacy and family roles.

16.3. Implementing Treat Me Well Campaign in the RBFT

Key achievements

- Trust Quality Account Priority 2020/21 – delay due to COVID pandemic carried over to 2021/22 to implement the 'Treat Me Well Campaign'
- The national "Treat Me Well" Campaign aims to improve the treatment patients with learning disabilities (LD) and Autism (ASD) receive in the NHS, through better communication, more time, and clearer information. These simple, reasonable adjustments, can make a huge difference to the experience of care as well as the clinical outcomes for patients, their carers and the staff looking after them
- An LD/ASD multi-professional working group established to support the ongoing improving of care for patients with a learning disability who attend the hospital
- LD/Autism training project underway to create videos for staff training, also to adapt to use as social story for patients with additional needs attending RBFT services
- Good links and pathways developed with hospital palliative care team and oncology services
- Dental pathway agreed for community patients with learning disability developed
- Building links with Florey clinic to identify and support people with learning disability accessing sexual health service
- LD nutrition pathway (including enteral nutrition and PEG insertion) reviewed
- NHSE & NHSI LD benchmarking audit submitted by the end of March 2021

Key Challenge

- Flagging adults with LD known to Berkshire West GPs and BHFT services on RBFT EPR

16.4. Patient Experience

- Positive feedback received from the families and carers of patients with learning and complex disability regarding their experience of accessing RBFT services. The overall message is that the planning for individuals which enables in-patient stays and out-patient visits to proceed smoothly is highly valued and appreciated.
- Families and carers feel confident in raising concerns with the LDLNs when they occur.

16.5. Familiar Carers

- RBFT continues to fund 1:1 familiar carers for inpatients with a learning disability who require that level of support to make them feel less anxious and more likely to comply with medical and nursing interventions in the hospital environment.
- Work continues on streamlining the payment process and taking it out of the job role of the LDLN team to improve timeliness and governance of payments. The LDLN service now have administrative support to improve this process.
- In the early part of the pandemic in 2020 we saw a considerable drop in familiar carers supporting patients on the ward on the advice of their employers and the local authorities. This gave rise to some challenges, but during this time, many staff were redeployed across the trust and additional staff were often able to provide some reassurance.

Key area of work for 2021/22

- To continue to progress Trust Quality Account Priority 2021/22 to implement the "Treat Me Well" campaign to support patients with learning disabilities in hospital
- To implement and facilitate training for the Oliver McGowan learning disability and autism training, and video training material for staff.
- Purchase a licence for Photo Symbols an IT package to be used by Patient Information Manager to support Easy Read information development for LD patients
- Consistent LD flagging, to ensure correct identification of patients with a learning disability and appropriate engagement from LDLN
- To improve transition arrangements through RBFT provision by:
  - Relaunching RBFT Transitions Steering Group to review current transitions, pathways, policies and protocols
  - Identifying the 'top ten' critical pathways in RBFT services
  - Map the journey of children and young people aged 14-25 in the 'top ten' pathways through the hospital and associated tertiary centres as pre-work for reconfiguration of services including shared care services

On-going Learning and complex disabilities – adults' challenges / risks:

- Increase in case complexity and managing the expectations of families, carers and other professionals
- Patients with LD being delayed in hospital waiting for appropriate social care placements.
- Affordability of funding familiar carers.
- Increasing and maintaining workforce knowledge of the Mental Capacity Act and best interest assessments.
- The introduction of Liberty Protection Safeguards due to be implemented in April 2022.
- Capacity of the Learning Disability Liaison Nurses to improve the service provision for young people during transition to adult hood
- Increase in the number and complexity of young people transitioning to adult services.
- Consistent LD Flagging

17. Risk Based Priorities for 2021/2022

17.1 Workforce capacity:

- Recruit Adult Medical Safeguarding Leads for UCG and PCG and review their capacity
- Review the capacity of the Named and Designated Doctors for Child Protection and Dingley medical team to manage a significant increase in demand for child protection medicals and the support needed for three local authorities by a locality paediatrician
- Review and continue to develop our Safeguarding Champions network.
- Continue to work with operational teams to monitor the impact of increased safeguarding activity/complexity on the workforce
- Work with Berkshire West ICP in relation to our capacity to support increased child protection, transition, CAMHS, SEND, adult mental health, learning disability and adult safeguarding activity and reforms including Child Death Review (CDR) Statutory and Operational Guidance 2018
- Work with Berkshire West ICP to identify additional investment in the LDLN team to support our Trust Quality Account Priority 2021/22 "Treat Me Well" campaign and the LeDeR mortality review programme

17.2 Workforce knowledge and capability:

- Review of existing training
  - COVID-19 recovery and restoration Safeguarding, Mental Health and LD re-launch to include a blend of eLearning, virtual and COVID safe face to face

  - Level 3 child safeguarding training for ED ST3s against their ARCP requirements
  - Safeguarding, mental health and learning disability induction for trainee doctors
  - Learning disability and ASD
  - Preventing, minimising, managing, challenging behaviour and V&A
  - Application in practice of the Mental Capacity Act and confidence of staff to assess mental capacity, understand DoLS/LPS and make best interest decisions
  - Domestic abuse, neglect and self-neglect, exploitation and concerns and allegations management.
- A gap analysis against standards specifically:
  - The Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health and Social Care Staff: 2018.
  - The Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: 2019.
  - The Intercollegiate Document Safeguarding children and young people: roles and competencies for paediatricians: 2019.
  - The Restraint Reduction Network Training Standards, 2019 commissioned by the NHS
  - Contextual Safeguarding; Trauma Informed Care; Adverse Child Hood Experiences and Think Family in the acute setting.
- Carryout a frontline practitioner self-assessment concerning the effectiveness of our safeguarding training arrangement
- Close monitoring of the impact of Covid on staff resilience and support where needed
- Succession planning across the system, consideration of peer mentoring to expand and diversify the experiences of safeguarding colleagues

17.3 Work with IG, IT informatics and EPR:

- To develop a plan to ensure safeguarding, mental health and learning disability is a priority in the development of the Digital Hospital.
- Progress integrated data and information sharing with 'Thames Valley Together' and Community Safety Partnerships to identify and tackle early factors that can lead to crime and put in place plans to prevent and reduce serious violence.

17.4 Address Health Inequalities through partnership working – including patient, family, staff and community engagement:

- To prepare for and implement the Liberty Protection Safeguards
- Participate in the ONE Reading Prevention and Early Intervention Partnership Board and work streams and support the development of their Adolescent Risk and Early Years Strategies and transformation work to better utilise Early Help services
- Support development and implementation of Berkshire West Safeguarding Children Partnership (BWSCP) priorities
- Support development and implementation of West of Berkshire Safeguarding Adult Board (SAB) priorities
- Engage with the Berkshire West LeDeR mortality review programme.
- Engage with Pan-Berkshire Suicide Steering Group to refresh the Pan Berkshire self-harm and suicide strategy with an early intervention and prevent across lifespan approach
- Engage with Reading Borough Councils Domestic Abuse Strategic Partnership Board

Integrated Care (ICP) and Integrated System (ICS) partnership working to:

- Influence and deliver the priorities of the Berkshire West ICP Mental Health and Learning Disability Programme Board including rough sleepers/homelessness and carers strategy
- Influence and deliver the priorities of the Berkshire West ICP Children and Young Peoples Programme Board including SEND, becoming Trauma Informed and Adolescent Risk

Appendices

Appendix 1 Indicative Statistics for the RBFT for Information & Background

	2016/17	2017/18	2018/19	2019/20	2020/21	Comments
Population number served	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	
% of population under 18 years	24%	25%	25%	25%	25%	
Number of adult attendances to ED	94,348	100,324	104,759	111,556	79,326	↓ 29%
Number of attendances by under 18s to ED	29,427	28,818	30,495	32,163	17,593	↓45%
No of over 65s attending ED	27,159	31,133	31,468	35,019	24,701	↓30%
No of mental health attendances at ED all ages	2778	3111	3728	3569	3138	↓ 12% CYP ↑ 5%
Number of adult admissions	92,791	99,737	102,228	103,730	89,018	↓ 14%
Number of admissions to paediatric wards	8589	8159	8197	7746	5252	↓32%
No over 65s admitted	86,410	83,954	85,686	87,779	71,915	↓18%
No over 75s admitted for >72 hrs	6449	5792	5865	5828	5,888	↑1%
No over 75s admitted for >72 hrs with cognitive issues	1582	553	672	812	831	↑2%
Number of in-patients referred to LDLNs	278	263	226	264	296	↑12%
No of patients admitted because of mental health issues	1610	1710	1841	1611	1249	↓23%
Number of babies born	5391	5183	4936	4858	4677	↓14%
Number of under 18s attending out-patient clinics	72,539	73,196	73,861	76,207	55,053	↓28%
Number of under 18s attending clinics providing sexual health services	2059	2032	1663	1622	482	↓70% *
Number of 18s admitted to adult wards	594	661	1059	1552	1275	↑ 214% since 16/17 ↓ 18% in 20/21
Dingley child protection medicals	112	114	143	147	143	↓3%
Number of employees	5470	5531	5431	5014	5511	↑10%
*The number of young people < 18 attending sexual health clinics dropped significantly. Walk-in services ceased in line with COVID guidelines, changes were made to access arrangements that included safeguarding assessments.						

Appendix 2 Summary of Training Activity 2020/21 and Plans for 2021/22

3.2 Safeguarding Adults Training

All staff are required to undertake safeguarding adults training to the level that their job requires. Adult safeguarding training has been reviewed following the publication of the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff, 2018, and an initial gap analysis completed. Level 3 adult safeguarding training programme will commence in 2021. Staff that make clinical and discharge decisions with patients need to be trained in the mental capacity act (MCA) and its application.

3.3 Safeguarding Children Training

All staff are required to undertake child protection to the level that their job role requires. Our child protection training is compliant with 'Intercollegiate Document: Child Protection Roles and Competencies for Health Staff, 2019'. In 2021/22 a gap analysis against new RCPCH 'Good practice service delivery standards for the management of children referred for child protection medical assessments' published in October 2020 will be completed. Due to the number of children and young people seen within the services of the Planned Care Group in 2020/21 a review of the number senior nurses trained in level 3 child safeguarding will be undertaken.

3.4 Child Sexual Exploitation/Child Criminal Exploitation (CSE/CCE) Training

CSE/CCE is embedded into safeguarding children training at all levels. All staff can access E-Learning via the CSE intranet pages. In 2021/22 there will be a BWSCP multiagency review and relaunch of contextual and complex safeguarding training that will include thematic learning from national and local reviews and address the understanding of our workforce in relation to weapon crime and the role of social media in the exploitation of children and young people. BWSCP training forums

3.5 Domestic Abuse

Domestic abuse is raised in adult and all levels of child safeguarding training; specific enhanced domestic abuse training is available for maternity staff, this has been reviewed and dynamically updated during 2020/21. Level 3 days for the children's workforce include clear guidance for staff who are working closely with children and families on how to support and refer to other agencies where there are parental risk indicators, we remind staff of the importance of routine questioning in relation to domestic abuse. There is a Domestic Abuse guide available to staff as part of the Safeguarding Tool Kit. In 2021/22 our Domestic Abuse Working Group will be relaunched and complete a gap analysis against the revised Code of Practice for Victims of Crime which came into operation on 1 April 2021, brought in by the Domestic Violence, Crime and Victims Act 2004 (Victims' Code of Practice) Order 2020.

3.6 Prevent (Anti-Terrorism Training)

Prevent awareness forms part of the level one training for all staff and is included in adult and child safeguarding training. The training requirement has been reviewed in line with NHS England guidance and selected staff mostly the children's workforce who require level 3 child protection training identified to receive additional training. This is either a face to face WRAP session or approved e-learning.

3.7 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

MCA and DoLS awareness are delivered as part of the part of Trust induction safeguarding adults training and core mandatory training day. For patient facing staff MCA enhanced training is delivered to a selected group of staff to achieve a minimum of 80% compliance. We have remained above this target level during 2020/21. The majority of MCA and DoLS training has been undertake as e learning during 2020/2. Enhanced MCA has been provided via MS teams virtually. Simple suggestions prompts and reminders for very busy people to 'Think MCA/DoLS/BIA' have been emailed periodically to all Consultants, Matrons, DoNs and safeguarding champions. In 2021/22 an advanced MCA, DoLS, BIA, LPA and consent training for medical workforce and nurses that take consent will be developed, arranged with and delivered by Capsticks. This will be a level 3 adult safeguarding training update.

3.8 Mental Health Training

The Lead Nurse Mental Health provides training to staff on the Mental Health Act (MHA), mental health disorders, stigma, and the processes in place within the hospital to support good patient care. This is delivered through the induction training programme for Registered Nurses (RNs), Allied Healthcare Professionals (AHPs) and Clinical Support Workers (CSWs). A Mental Health study day runs four times a year. It is available to ED, Acute Medical Unit and Short Stay Unit nursing staff and includes situational discussions, suicide and self-harm awareness and risk assessment. Topics include mental health disorders, a basic understanding of the Mental Health Act, Mental Capacity Act, and has input from speakers from BHFT, the Samaritans and addictions services. In 2020/21 all days were face to face, numbers of staff attending were limited due to Covid-19 restrictions. The clinical team from the Gastroenterology ward attended one session prior to restrictions and requested places going forward. Other specialities have expressed an interest in attending or developing their own study day. A Mental Health Act Quick Guide is available on the intranet as part of the Safeguarding Tool Kit. A mental health session features in the 1:1 care training day for RNs and CSWs and includes the need for 1:1 mental health observations and how staff respond to, interact with and assess risk in patients. During 2020/21 in collaboration with Elderly Care, PMS and the Trust Lead Nurse for Mental Health a number of short mental health teaching videos have been developed and are available on the intranet. In collaboration with BHFT the "We Can Talk" training programme, commissioned by Health Education England and designed to improve the experience of children and young people in mental health crisis is being rolled out in Paediatrics. Perinatal Mental Health training for the multidisciplinary team in maternity services has continued using a virtual national training package and maternal mental health in house scenario sessions. Speciality specific face to face Mental Health Act training by the PMS Psychiatrists which has been offered and taken up in previous years, was suspended during 2020/21, this will be reviewed and offered again in 2021/22.

3.9 Allegations and Safer Recruitment training

Safeguarding concerns and allegations awareness is delivered as part of child and adult safeguarding core mandatory training. In 2021/22 we will increase safeguarding awareness amongst Employee Relations Team and other teams as appropriate and review our training for investigators in light of lessons learnt during the Covid- 19 pandemic.

3.10 Conflict Management Training and Training in Physical Restraint and Holding

Security staff are trained in physical restraint; and qualified in Caring Intervention level 3 Control and Restraint.

Established conflict resolution training provided by our Local Security Management Specialist (LSMS) continues with a focus on frontline staff. This includes breakaway techniques and understanding of the application of the Mental Capacity Act, the importance of space and communication skills. Restraint in relation to clinical treatment and best interests is discussed in adult safeguarding training and Level 3 child protection training. We have a Preventing, Minimising and Managing Aggressive and Violent Behaviour Including Restraint Policy CG669.

A Zero Tolerance steering group was established in October 2020 and we launched a Trust-wide zero tolerance to challenging behaviour, violence and aggression campaign, with 'I'm here to help, not to be hurt' posters. In December 2020 an Emergency Department (ED) zero tolerance pilot was started using yellow, amber and red cards that can be shown to visitors and patients who are wilfully displaying unacceptable behaviour. Prompts on the back of each card assist staff in communicating the significance and potential consequences of the person's actions clearly, calmly and with confidence. In 2020 funding was identified and pilots of full day training for frontline clinical staff that comply with Restraint Reduction Network (RRN) Training Standards delivered by an external company were commissioned. The training includes Positive Approaches to Behaviour, Introduction to De-escalation Strategies, Personal Safety & Disengagement, Redirection and Guiding, Clinical Holding. The training is aimed at clinical staff working with patients' with cognitive impairment where better anticipation, understanding of triggers and making reasonable adjustments improves personal safety for staff and reduces unnecessary or unlawful restriction or restraint for patients. 12 full introductory days for frontline clinical staff were commissioned from October 2020 – July 2021, sufficient for 144 staff. Additionally a 5-day train the trainer course for 4 people and a 3-day course for speciality coaches for 8 people have been arranged. In 2021/22 following the training pilots, there

will be a full evaluation and comprehensive training needs analysis to allow for the development of a business case to provide a sustainable and affordable training model that includes a consistent approach to debriefs and staff support post incidents. A bespoke training programme covering clinical and therapeutic holding and low-level restraint techniques for paediatrics has been commissioned from BHFT. This will cover 8 days of training, sufficient for 64 staff.

3.11. Transition Training

During 2020/21 specialties' have generally been expected to maintain the knowledge and skills of their staff in relation to transition through ward and department training. The Learning Disability Liaison Nurses work with adult clinicians to improve understanding of the cognitively disabled young person moving to adult services. Dingley Child Development Centre multiagency team are knowledgeable, skilled in transitioning young people with Neurodisability and Epilepsy through to adult services. In 2020/21 the Paediatric Consultant in Neurodisability provided transition to adulthood training sessions for Adult Respiratory colleagues. Audiology Services have 'Guidelines for transition from paediatric to adult hearing services' GL586 and the Paediatric Diabetes team have 'Transition to adult services for young people with diabetes' - GL658 both specialities are knowledgeable and skilled and provide a robust service for transitioning young people to adult hood. In 2021/22 we will participate in the NHSE/I CYP Transformation Programme Team, Core Capabilities Framework for the Transition of Young People into Adult Services in England-national consultation. The Framework describes the core knowledge, skills and behaviours required by all healthcare staff working with young people who are transitioning to adult services. Currently there is no national framework that addresses this need. Additionally we will re-launch the RBFT Transition to Adulthood Steering Group to complete a training needs gap analysis as part of our review of 'Transition from Paediatric to Adult Services Policy and Guidelines CG562'.

3.12 Learning Disabilities (LD) And Autism (ASD)

A DVD is shown at core induction; there are 'raising awareness' sessions for RNs, AHPs and CSW's as part of nurse/CSW induction. A communication session is delivered on a training day for care crew teams and others who are providing 1:1 support. The Learning Disability Liaison Nurses work with clinical teams to improve understanding of the cognitively disabled patient in an acute health setting. In 2020 Dr Sarah Hughes, Paediatric Consultant in Neurodisability arranged and led a multiagency Level 3 Safeguarding Disabled Children training day for BWSCP.

This one-off single day training course was run by a multiagency group of presenters. We had around 50 attendees, from a wide variety of backgrounds to consider safeguarding in its broadest context for our most vulnerable children and young people. Improving learning disability and ASD training is an important element of the Trust Quality Account Priority 2020/21, delayed due to the COVID pandemic and carried over to 2021/22 to implement the "Treat Me Well" campaign to support patients with learning disabilities in hospital. A multidisciplinary LD/ ASD working group was established in 2020/21 to support the ongoing improving of care for patients with a learning disability who attend the hospital and oversee the implementation of the "Treat me Well" campaign. Funding has been identified to review our training offer for LD/ASD and a project is underway to create videos for staff training, which can be adapted to use as social stories to prepare patients with additional needs attending RBFT services.

In 2020/21 Berkshire West CCG developed a 15 min video about GP Annual Health Checks: Covid and Beyond for young people over the age of 14 and adults with LD this can be used as CPD for our staff and is helpful for families. Additionally in 2021/22 we will provide LD & autism awareness presentations through our speciality clinical governance meetings; we have been accepted by the National Autistic Society as a pilot site for Oliver McGowan Mandatory training tier 1 (29th October & 11th November) tier 2 (27th September) and we will explore commissioning targeted training from Autism Berkshire.